MAGNACARE℠ | Rx

Prescription Drug Program
Mail Service Form

Mail Order Prescriptions Made Easy!

The Mail Service Enrollment Form is only needed for first time orders, dependents who have been added since the last order, or changes to current information.

To start your Mail Service Benefit, use one of the following convenient steps:

Option 1

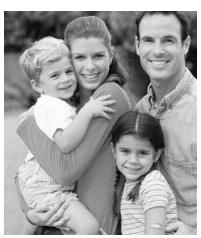
Enroll online at **www.magnacarerxmail.com.** Mail your prescriptions to MagnaCareRx or have your **prescriber** fax them to us at 877-221-1259.

– OR –

Option 2

Enroll by completing this form and mail it back to MagnaCareRx. Include your prescriptions or have your **prescriber** fax them to us at 877-221-1259.

Please Note: Only prescribers may fax prescriptions to a pharmacy.



MagnaCareRx
PO Box 90369
Lakeland, FL 33804-0369
Toll-Free: 888-648-6766
Toll-Free Fax: 877-221-1259
www.magnacarerxmail.com

MagnaCareRx Will Contact Your Prescriber for New Prescriptions

Complete this section only if requesting new mail order prescription(s) from your prescriber.
We substitute generics on prescriptions unless otherwise noted by your prescriber.

Patient Name	Date of Birth	Medication Name and Strength	Prescriber's Name, Phone Number and Fax Number

Once MagnaCareRx has received all necessary and correct information, orders will ship within 2 to 3 business days.

How to Order New Medication

1. Complete the attached form to begin ordering your maintenance prescription medications from MagnaCareRx mail service pharmacy. This form is only needed for new members, first time orders, or dependents that have been added since the last order. Be sure to complete your method of payment.
2. Include the form and any prescriptions you may have in the attached envelope. Remember to write your Member I.D. and Date of Birth on your prescriptions.

MagnaCareRx will dispense the days supply as written by the prescriber. For example, if your prescription is written for 30 days and your plan allows 30 day fills at mail order, MagnaCareRx will fill the 30 day supply as written. If your prescription is written for 30 days, and your plan only allows 90 days, we will contact you regarding the status of your order and how to best meet your needs.

To save time, please look at your prescription before you leave your prescriber's office. Check the drug name, quantity and days supply. The days supply should match the number of days you want us to provide with each refill. Please review your Plan benefits for the maximum days supply your Plan will allow with each mail order fill.

How to Order Refills

To place a refill order, please visit **www.magnacarerxmail.com** or call **888-648-6766 prompt 2** approximately three weeks prior to depletion of your medication supply.

Savings

Mail Service can save you money. To find out the cost for your mail order medication, contact our Member Services team.

Where appropriate, MagnaCareRx uses generic medications to fill your prescriptions. The FDA requires that all drugs be safe and effective. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risks and benefits as their brand name counterparts.

Quality is Our First Priority

The MagnaCareRx Mail Service Pharmacy is staffed by registered pharmacists and certified pharmacy technicians. With advanced robotics and state-of-the-art technology, our highly trained professionals conduct multiple quality and accuracy checks on your order.

Your prescription order will be shipped using US Mail or UPS. Refrigerated items are shipped in accordance with FDA and Manufacturers specifications. For your security, some controlled substances are shipped UPS Ground with a tracking number and may require a signature.

To learn more about our Mail Service Pharmacy, please visit our web site at **www.magnacarerxmail.com** or call us at **888-648-6766**.

MAGNACARERX
PO BOX 90369
LAKELAND FL 33804-0369

Postage Required
Post Office will not deliver without proper postage.

Please fold and seal along this line.

Mail Service Enrollment Form

Cardholder's Last Name | First Name | Middle Initial | Date of Birth (mm/dd/yy)

Primary Address | City | State | Zip Code

Shipping Address (if different than Primary Address) | City | State | Zip Code

Primary Phone — — | Secondary Phone — —

Group Name (Primary) | Group ID# | Member ID#

Group Name (Secondary) | Group ID# | Member ID#

Please Charge My: ❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

Credit Card #: — — — | Expiration Date /

Cardholder's Name: | Signature*

***Credit Card Will Be Used For All Future Orders.**

Remember to write your Member I.D. and Date of Birth on your prescriptions.

Once MagnaCareRx has received all necessary information, orders will ship within 2 to 3 business days.

Patient Profile

Member Information

DRUG Allergies

Primary Cardholder's First Name	Date of Birth (M M / D D / Y Y Y Y)	Male/Female(M/F)	None	Amoxicillin	Aspirin	Cephalosporins	Codeine	Erythromycin	Penicillin	Sulfa	Tetracyclines	Other (Please Specify)
	/ /											
Spouse's First Name	/ /											
Other Dependent's First Name	/ /											
Other Dependent's First Name	/ /											
Other Dependent's First Name	/ /											
Other Dependent's First Name	/ /											

Please enclose additional family member information on a separate piece of paper.

Acknowledgement: MagnaCareRx will substitute FDA approved generic equivalent drugs for any brand name medication(s) ordered unless specified by the prescriber or me on each prescription. I will take personal responsibility for payment of all medications that I or my family members receive.

Remember to write your Member I.D., Date of Birth, Brand/Generic preference and Fill Now or Hold on each prescription sent in.

Signature _____ Date _____

Enclose with prescription(s)