

# Immediate Pharmaceutical Services Member Prescription Order Form

## Member Information

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

## Current Address

Street Name: \_\_\_\_\_

City: \_\_\_\_\_

Member I.D. Number: \_\_\_\_\_

State

Zip Code

Daytime Area Code and Phone Number

Evening Area Code and Phone Number

## Profile Updates / Adds

**\*\*Please note any CHANGE in medical condition or allergies\*\***

Check all that apply Please Print First Name Clearly	Prescription Enclosed (Yes or No)	DATE OF BIRTH			GENDER		ALLERGIES							HEALTH CONDITIONS									
		Month	Day	Year	Male	Female	None	Aspirin	Codeine	Erythromycin	Penicillin	Sulfa	Other-Specify	Asthma	Diabetes	Glaucoma	Heart Condition	High Blood Pressure	Seizure Disorder	Thyroid	Ulcers	Other-Specify	

If additional space is needed, please list other allergies or health conditions:

## Prescription & Payment Information

Number of Rx's Enclosed

Co-Payment \$ = \$ Enclosed

Payment Method

New Prescriptions  ×

\$  = \$

Refill Prescriptions  ×

\$  = \$

Total

Total \$

Visa  Money Order

MasterCard  Check

Discover

**Do Not Send Cash**

Refill Numbers:

Credit Card Number

Expiration Date

**PLEASE MAKE CHECK PAYABLE TO**

**Immediate Pharmaceutical Services  
P.O. Box 166  
Avon Lake, OH 44012**

Unless box below is checked, your credit card will be kept on file and you are authorizing its use for future orders.

I do not want my credit card used for future orders.

Signature \_\_\_\_\_

## Authorization

PLEASE READ AND SIGN: I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, and I AUTHORIZE IMMEDIATE PHARMACEUTICAL SERVICES TO SUBSTITUTE FDA APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSABLE AND CONSISTENT WITH MY PHYSICIAN'S ORDERS AND MY BENEFIT PLAN.

Signature \_\_\_\_\_ Date \_\_\_\_\_