# Fax Order Form

**NOTE: ORDERS NOT FAXED FROM A LICENSED PHYSICIAN'S OFFICE WILL NOT BE PROCESSED.**

**Physician:** Fax completed form to PrimeMail™ Pharmacy at **877.774.6360**.

**Patient:** PrimeMail Pharmacy is your mail service pharmacy. Please make every attempt to obtain a new written prescription from your physician and send it with your Blue Cross order form and payment to: **PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**

Follow these steps to obtain your prescription:

- Complete the Member, Patient and Payment Sections below using **black ink** only. A credit card number is required at the time the form is submitted.
- Ask your doctor to fill out the Prescription Section and fax this form to **877.774.6360.**
- Please allow 10 to 14 days for delivery from the date your physician faxes in your prescription.

**By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Blue Cross and Blue Shield's use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**

## MEMBER SECTION (MUST COMPLETE EVERY FIELD)

| Member ID Number | Member Date of Birth | Group Number (copy from your ID card) |
|---|---|---|
| | | |

| Member Name (First, M.I., Last) | Daytime Phone | Evening Phone |
|---|---|---|
| | | |

| Address (please do not use a P.O. box) | Email Address |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

## PATIENT SECTION

| Patient Name (First, M.I., last if different from member) | ❑ Male ❑ Female | Patient Date of Birth |
|---|---|---|
| | | |

Patient Email Address

**PATIENT ALLERGIES**

- ❑ None Known
- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Other Allergy _____ _____

**PATIENT CONDITIONS**

- ❑ None Known
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Condition
- ❑ Hypertension
- ❑ Ulcer
- ❑ Other Condition_____

| Physician Name | Physician Phone |
|---|---|
| | |

**PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.**

## PAYMENT SECTION

Credit Card Number

Expiration Date (MM/YYYY)

- ❑ American Express
- ❑ MasterCard
- ❑ Discover
- ❑ Visa

Credit Card Holder's Signature

BlueCross BlueShield of Illinois

**DO NOT FAX PRESCRIPTIONS FOR CONTROLLED SUBSTANCES.**

## PRESCRIPTION SECTION

Rx

For _____ Date _____

Address _____ Phone _____

Dr _____ Dr _____

Dispense as written — Substitution permissible, may substitute

Physician Name (Please print) _____

Refills _____ Times Address _____

DEA# _____ Phone _____

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