PruittHealth PHARMACY SERVICES

Registration and Prescription Order Form

Your Location Name: _____ Facility #: _____

Use this form to register/submit your first prescription order. Please print clearly using only BLACK INK and UPPERCASE letters. Fill in the applicable circles completely (●). **Not all ID and Group Number boxes may be needed. DO NOT staple, tape or paperclip anything to this form.**

MEMBER INFORMATION ○ Male ○ Female Date of Birth [MM/DD/YYYY]: ☐☐/☐☐/☐☐☐☐ Prescription Benefit Provider/Pharmacy Drug Insurance: _____

Member ID Number *(Located on card)*

Suffix *(If on card)*

Group Number

Email Address *(To receive information regarding the processing of your order)*

Last Name

First Name

Cell Phone Text Msg: ○ Yes ○ No

Permanent Address

Daytime Phone

City

State ZIP Code

Primary Cardholder Social Security No.

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

MEMBER	
Allergies	Order Preference
○ Aspirin ○ Cephalosporin ○ Codeine derivatives ○ Morphine derivatives ○ Penicillin ○ Sulfa drugs ○ None known ○ Other (use lines below) _____ _____	○ Easy-open caps ○ Automatic Refill* **You must notify the pharmacy to remove discontinued medications from automatic refill.*
Brand names are the property of their respective owners.	

1. **Allow 10 business days from receipt of prescription for medications to arrive.**
2. **Any missing or illegible information may lead to a delay in delivery.**
3. **Notify PruittHealth Mail Order Pharmacy with any change of address, payment type or any other information to avoid delay in delivery.**
4. **Complete payment information on back of this form to avoid delay in delivery.**
5. **Medicine cannot be returned to pharmacy once it has been shipped.**

Standard Ground Delivery is provided at no charge. Special delivery requests are available at additional charge. **Please allow 10 business days from the time that you place your order to receive your prescription(s).** A refill order form will be included with your shipment.

It is standard pharmacy practice to substitute generic equivalents for brand-name medications. PruittHealth Pharmacy Services will dispense an FDA-approved generic equivalent if available, permitted by your prescriber and allowed by state law. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Support Line at 855-5-RX-Pharm (855-579-7427).

By submitting this form, you have authorized release of all information to PruittHealth Pharmacy Services and other necessary parties as required to process your order under your benefit plan.

DEPENDENT INFORMATION

○ Male
○ Female

Date of Birth [MM/DD/YYYY]: ☐☐/☐☐/☐☐☐☐

Dependent Last Name

Dependent First Name

Suffix *(If on card)*

Email Address *(To receive information regarding the processing of your order)*

Prescriber Last Name

Prescriber First Initial

Prescriber Phone ☐☐☐-☐☐☐-☐☐☐☐

Prescriber Fax ☐☐☐-☐☐☐-☐☐☐☐

For separate shipping, please contact the Customer Support Line toll-free at 855-579-7427

DEPENDENT	
Allergies	Order Preference
○ Aspirin ○ Cephalosporin ○ Codeine derivatives ○ Morphine derivatives ○ Penicillin ○ Sulfa drugs ○ None known ○ Other (use lines below) _____ _____	○ Easy-open caps ○ Automatic Refill

PAYMENT INFORMATION

Payment Options: *Payment is required at time of order. Please do not send cash.*
We accept Discover®, MasterCard®, American Express®, and Visa®.

○ Place credit card below on file for this and all future orders

○ Charge credit card below for this order

○ Payroll deduction

Credit Card Number:
○ Discover ○ MasterCard ○ American Express
○ Visa ○ FSA/HSA Card

Expiration Date [MM/YY]: ☐☐/☐☐ CVV Code: ☐☐☐☐

I authorize PruittHealth Pharmacy Services to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my balance and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature: _____

Date: _____

I authorize the deduction from my paycheck of the amount of my prescription purchase from PruittHealth Mail Order Pharmacy. I understand that if my employment is terminated prior to paying for prescriptions received, the company will recoup any amount due from my final paycheck to the extent allowed by law. I understand that upon termination I am responsible for payment of any outstanding balance not covered by payroll deduction.

Partner Signature: _____

Date: _____

For registrations only, you may fax this completed form to 855-890-7300.

Please print your name and date of birth on all prescriptions; enclose them along with this completed form and mail to:

PruittHealth Mail Order Pharmacy
4024 Stirrup Creek Drive, Suite #120
Durham, NC 27703

Fax: 855-890-7300
Telephone: 855-5-RX-Pharm (855-579-7427).
Email: refills@pruitthealth.com