



New Prescription Order Form



Mail this form to:
PrimeMail®
PO Box 650041
Dallas, TX 75265-0041

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or call 855.457.0408
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CARDHOLDER INFORMATION

Cardholder's ID _____ Cardholder's Date of Birth (mm/dd/yyyy) _____

Cardholder's Last Name _____ Cardholder's First Name _____ MI _____

Patient's Last Name (if different than cardholder) _____ Patient's First Name _____ MI _____

Patient's Gender: Male Female Patient's Date of Birth (mm/dd/yyyy) _____ Patient's Phone Number _____

Patient's Permanent Address _____

City _____ State _____ Zip Code _____

Patient's Email Address _____ Contact by: Email Phone _____

DRUG ALLERGIES

- None Codeine Sulfa
- Aspirin Erythromycin Penicillin
- Other _____

HEALTH CONDITIONS

- Arthritis Diabetes Glaucoma High cholesterol
- Asthma Depression Heart condition Hypertension
- Other _____

PATIENT'S NEW PRESCRIPTIONS

Drug Name	Physician/Prescriber's Name & Phone Number	Do not fill at this time
		<input type="radio"/>
		<input type="radio"/>
		<input type="radio"/>
Total Number of Prescriptions: _____		

Mail the original physician-signed prescriptions with this completed form. For multiple dependents please use multiple forms. If more than 3 prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order. Additional processing time may be required for prescriptions that require physician clarification. For prescriptions to be filled at a later date, call the customer service number above to activate.

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