

DRUGSOURCE, INC.

Home Delivery Service

A PROGRAM FOR PRESCRIPTION AND NON PRESCRIPTIONS ITEMS

ENJOY THE CONVENIENCE OF

- Shopping from home
- Home delivery
- Mail order is cost effective when compared to local pharmacy
- Toll free number available 24/7
- We can contact your doctor for refill authorization
- Doctor can phone or fax in orders
- Pharmacist available 24/7 for consultation
- Prescriptions processed within 24-48 hours of receiving
- Receive shipping confirmation when you provide your e mail address

Orders Can Be Placed By:
Mail Phone
Fax E-Mail

New Rxs can be faxed from MD only

DRUGSOURCE, INC.

P O BOX 1366
 ELK GROVE VILLAGE, IL 60009-1366
 (800) 854-8764
 Fax (847) 258-1913
 www.drugsourceinc.com

PLEASE FILL OUT THIS SIDE OF CARD COMPLETELY IF YOU HAVE ELIGIBLE DEPENDENTS
 If an eligible dependent in your family has any drug allergies, medical conditions, is sensitive to any drugs, or is pregnant, list below. If you have no eligible dependents, check here -

Spouse

Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

Dependents

1. Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

2. Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

3. Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

PLEASE FILL OUT SECTION BELOW IF YOU WANT US TO CONTACT YOUR PHYSICIAN

Medication Name	Strength	Quantity	Prescription Directions	Doctor Information		Patient	
				Name: Phone: Fax:	Name: Phone: Fax:	Fill Now	Fill Later

How To Order

- Before leaving your doctor's office:
 - If you need medication on a long-term, regular basis (called maintenance medication), ask your doctor to prescribe up to a 90 day supply. **DRUGSOURCE, INC.** will only dispense the amount of medication that your doctor has prescribed up to a 90 day supply.
 - Discuss generics. Ask your doctor to prescribe generic medication whenever possible. **DRUGSOURCE, INC.** will fill your order with a generic drug, if one is available, if both you and your doctor agree to a generic substitution.
 - If you already have a prescription, make sure it clearly shows your doctor's name and address, exact dosage and patient's name. Please print the patient's name and date of birth on the back of each prescription.
- DRUGSOURCE, INC.** will accept a personal check, money order or major credit card. Remember to complete the Patient Profile Form and enclose the form with the appropriate co-payment and original prescription(s) in the return reply envelope. **DO NOT SEND CASH.** If using a credit card, please include your card number and expiration date with your order.

Please Note: According to Illinois State Law, if you are using a Schedule II narcotic such as Ritalin, Adderall, Concerta, Duragesic patches, etc., you need to submit a written prescription to us within seven (7) days from the date written on the prescription. Some states don't allow an out of state pharmacy to fill Schedule II prescriptions, or may restrict quantities.

CUT ALONG DOTTED LINE

Shaded Fields Must Be Filled IN DRUGSOURCE, INC. PATIENT PROFILE FORM

COMPANY NAME

GROUP NO.

Check here if new address

E-Mail Address for shipping confirmation

For your safety, we maintain a Patient Profile Record, so please complete both sides and return with your order.

Employee's Name (Please Print)

First

Middle initial

Last

Address

Street

Apartment Number

Phone Number

City

State

ZIP

Shipping Address if different

Employee's Date of Birth / / Male Female

Are you pregnant at this time? Yes No

Describe employee's drug allergies and medical conditions:

Check here if none:

Print name of Physician ordering medication:

Physician's Telephone Number: _____ Physician's Fax Number: _____

Employee's I.D. Number:

I authorize DrugSource to dispense generic medications. Yes No

Would you like a call from a Pharmacist to discuss any medical questions that you may have? Yes No

I understand that refusal of generic medications may impact my co-payment.

(Signature Required) X _____

If you are ordering a refill of a prescription on our file, list the Rx number(s) and the medication name(s) from your bottle label below on one of the lines.

Amount of co-payment enclosed \$ _____ Check Enclosed (\$20 returned check service charge will apply)

Please charge my credit card

VISA

MASTERCARD

AMERICAN EXPRESS

DISCOVER

Credit card number _____

Expiration date _____

CERTIFICATION STATEMENT

IMPORTANT: I certify the information on this form is correct. I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, and sponsor in accordance with the Health Insurance Portability and Accessibility Act (H.I.P.A.A.).

Employee's Signature X _____

Date / / _____