

# MAIL SERVICE

## Patient Information and Order Form

PO Box 779

 Mechanicsburg, PA 17055-0779 • Phone: 1-877-723-6005 • TDD Phone: 1-888-907-0020 • Fax: 1-888-907-0040 • [www.benecardpbf.com](http://www.benecardpbf.com)


Complete this form to order new prescriptions or refills.

 For convenient service, order refills or check benefit information at [www.benecardpbf.com](http://www.benecardpbf.com) or call **1-877-723-6005**.

|                    |                 |              |
|--------------------|-----------------|--------------|
| _____              | _____           |              |
| (Cardholder ID #)  | (RxGRP)         |              |
| _____              |                 |              |
| (Cardholder Name)  |                 |              |
| _____              |                 |              |
| (Shipping Address) |                 |              |
| _____              |                 |              |
| (Shipping Address) |                 |              |
| _____              |                 |              |
| (City, State, Zip) |                 |              |
| _____              | _____           | _____        |
| (Daytime Phone)    | (Evening Phone) | (Cell Phone) |
| _____              |                 |              |
| (E-Mail Address)   |                 |              |

Please be aware that certain medications cannot be delivered to a post office box.

☐ Is this a temporary address change?

☐ Is this a permanent address change?

If so, be sure to contact your plan administrator.

☐ Check here if it is OK to contact you via text message.

| New Prescriptions and Patient Information |                                                                            |                                                                                                                                      | Complete section below for each person submitting prescription(s) and enclose new prescription(s) in envelope along with form. |                                               |                                                                                                                                                                                |
|-------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient Name                              |                                                                            |                                                                                                                                      | Prescriber Name                                                                                                                | List Allergies/Health Conditions or Misc Info |                                                                                                                                                                                |
| DOB                                       | Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Relationship To Cardholder<br><input type="checkbox"/> Self<br><input type="checkbox"/> Spouse<br><input type="checkbox"/> Dependent | Prescriber Phone #                                                                                                             | # of Rx's enclosed for this patient.          | <input type="checkbox"/> Check here for easy open caps<br>If you do not permit substitution with a lower cost or generic medication, indicate here by listing the medications. |
| Patient Name                              |                                                                            |                                                                                                                                      | Prescriber Name                                                                                                                | List Allergies/Health Conditions or Misc Info |                                                                                                                                                                                |
| DOB                                       | Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Relationship To Cardholder<br><input type="checkbox"/> Self<br><input type="checkbox"/> Spouse<br><input type="checkbox"/> Dependent | Prescriber Phone #                                                                                                             | # of Rx's enclosed for this patient.          | <input type="checkbox"/> Check here for easy open caps<br>If you do not permit substitution with a lower cost or generic medication, indicate here by listing the medications. |
| Patient Name                              |                                                                            |                                                                                                                                      | Prescriber Name                                                                                                                | List Allergies/Health Conditions or Misc Info |                                                                                                                                                                                |
| DOB                                       | Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Relationship To Cardholder<br><input type="checkbox"/> Self<br><input type="checkbox"/> Spouse<br><input type="checkbox"/> Dependent | Prescriber Phone #                                                                                                             | # of Rx's enclosed for this patient.          | <input type="checkbox"/> Check here for easy open caps<br>If you do not permit substitution with a lower cost or generic medication, indicate here by listing the medications. |

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**PA STATE LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG FOR A BRAND NAME DRUG UNLESS YOU OR YOUR PHYSICIAN DIRECT OTHERWISE.**

If you do not want a less expensive brand or generic medication, please indicate above where requested.

Please note that you may pay more for a brand name drug if your prescription plan dictates.



Please see reverse side for additional information.

**Refills**

For convenient service, order refills or check benefit information at  
[www.benecardpbf.com](http://www.benecardpbf.com) or call **1-877-723-6005**.

Patient Name

Rx #

Medication

Patient Name

Rx #

Medication

Patient Name

Rx #

Medication

Patient Name

Rx #

Medication

Patient Name

Rx #

Medication

**Payment Information**  
**DO NOT SEND CASH**

Please make check or money order payable to **Benecard Central Fill**.

Write your member ID # on the check or money order.

(Checks returned for insufficient funds will be subject to a \$40 processing fee.)

Complete section below if paying by credit card.

We accept Visa®, MasterCard®, Discover®, American Express®.

\_\_\_\_\_  
Credit Card Number\_\_\_\_\_  
Exp. Date\_\_\_\_\_  
Credit Card Holder Signature\_\_\_\_\_  
Date

☐ Visa    ☐ MasterCard    ☐ Discover    ☐ American Express

☐ Check here to keep this card on file. We will bill your card for future orders and any outstanding balances for all persons in the family.

If the Credit Card Billing Address is NOT the same as the Shipping address, please specify Credit Card Billing Address below.

\_\_\_\_\_  
(Credit Card Billing Address)\_\_\_\_\_  
(Credit Card Billing Address)\_\_\_\_\_  
(City, State, Zip)

Your credit card will be charged according to your prescription plan and expedited shipping (if requested).  
There is no additional charge for standard delivery. (Allow up to two weeks for delivery.)

Check one of the boxes below for faster delivery. (Charges are subject to change.)

☐ 2nd Business Day -- \$15

☐ Next Business Day -- \$20

(Expedited shipping will not affect processing time of your order; it will only affect the shipping time.)

If prescriptions for more than one person are sent to us in the same envelope,  
we may send the medications together in one package unless otherwise directed.

