Medco By Mail ORDER FORM

UnitedHealthcare®
A UnitedHealth Group Company

1 Customer information: Please verify or provide customer information below.

Subscriber #: _____

Rx Grp #: UHEALTH

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
_____@_____.____

☐ New shipping address:

(Medco will keep this address on file for all orders from this subscriber until another shipping address is provided by any person in this plan.)

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in one envelope.

First name ☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

First name ☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Medco Health Solutions, Inc.**, and write your subscriber ID number on the front. You can enroll for e-check payments and price medications at **www.myuhc.com**, or call **1-800-948-8779.**

Number of prescriptions sent with this order: ☐

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ AmEx ☐ Diners

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date ☐☐ ☐☐
M M Y Y

X _____
Cardholder signature

☐ I authorize Medco to charge this card for all orders from any person in this plan.

☐ Rush the mailing of this shipment ($15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

First name | Last name

Birth date (MM/DD/YYYY) | Sex ☐ M ☐ F | Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name | 1st initial | Doctor's phone number

Important reminders and other information

Ask your doctor to write your prescription for a 90-day supply with refills when appropriate. You will be charged a mail order copayment regardless of the days' supply written on the prescription. Please be sure that your doctor writes your prescription for a 90-day supply, not a 30-day supply with three refills.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your pharmacy benefit materials to determine the best way to get Medicare Part B medications and supplies. Or, call the Customer Care number on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1-800-MEDICARE (1-800-633-4227).

Automatic generic equivalent substitution of certain brand-name medications is allowed by law in Texas, Florida, and Ohio, unless you or your doctor specifically directs otherwise.

☐ If you live in Texas, you have a right to refuse safe, effective generics. Check the box **if you do not want** the generic medication. This applies only to the prescription medication(s) on this order.

☐ Pennsylvania law permits pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your doctor direct otherwise. **Check the box if you do not wish a less expensive brand or generic medication "product."** Please note that this applies only to new prescriptions and to any future refills of that prescription.

For additional information or help, visit us at **www.myuhc.com** or call the Customer Care number on your ID card. TTY/TDD users should call 1-800-759-1089.

Mailing instructions: Place your prescription(s), this form, and your payment in an envelope addressed to:

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
P.O. BOX 747000
CINCINNATI OH 45274-7000