MedImpact Direct®
Medication Order Form

MedImpact Direct Customer Service
Toll-Free Phone # (855) 873-8739
Email: customerservice@medimpactdirect.com
www.medimpactdirect.com

For refills, please call us or log into your account at www.medimpactdirect.com

Member Information – Please use black or blue ink and CAPITAL LETTERS only

Last Name	First Name	MI	Suffix

Member ID	Plan Name

Date of Birth	Gender ☐M ☐F	Number of New Prescriptions	Group Number

Mobile Phone (Include area code)* ☐Set as Preferred Phone	Home Phone (Include area code)* ☐Set as Preferred Phone

Shipping Address Line 1 ☐Use this address for this order only	Billing Address (If different from Shipping Address) Line 1 ☐Check if same

Shipping Address Line 2	Billing Address Line 2

City	State	Zip Code	City	State	Zip Code

Email Address (Email used for order status updates)

Health Information

Allergies	☐Aspirin	☐Erythromycin	☐Penicillin	☐Tetracyclines
☐None	☐Cephalosporins	☐NSAIDs	☐Quinolones	☐Other _____
☐Amoxil/Ampicillin	☐Codeine	☐Peanuts	☐Sulfa	_____
Health Conditions	☐Asthma	☐Glaucoma	☐High Cholesterol	☐Thyroid Disease
☐None	☐Cancer	☐Heart Condition	☐Osteoporosis	☐Other _____
☐Arthritis	☐Diabetes	☐High Blood Pressure	☐Pregnancy	_____

Physician Information

Physician Last Name	Physician First Name

Physician Phone (Include area code)	Physician Fax (Include area code)

*When you provide these numbers, we have your permission to contact you at these numbers about your MedImpact Direct account. Your consent allows us to use text messaging, prerecorded voice messages and automated dialing technology for informational services calls, but not for telemarketing or sales calls. Message and data rates may apply. You may contact us any time to change these preferences.

Revision 06.30.17
FL 880-2638 V11

MedImpact Direct®
Medication Order Form

MedImpact Direct Customer Service
Toll-Free Phone # (855) 873-8739
Email: customerservice@medimpactdirect.com
www.medimpactdirect.com

Payment Information – Do not send cash

For fastest service, pay by credit or debit card. We accept VISA, Mastercard or Discover. If you need to pay by check or money order, please call to speak with a representative.

Cardholder Last Name	Cardholder First Name

☐ Charge my payment method on file (Returning Customers)
☐ Charge my NEW credit card: ☐ Visa® ☐ Mastercard® ☐ Discover®

☐ Ship Expedited Delivery
(Add $25 to my prescription amount)

Credit Card Number	Expiration Date	Security Code

Standard shipping is free. Your order can take up to 10 days for delivery from the date we receive your order. You may choose expedited delivery via USPS Priority Mail for an additional $25 by checking the box above. Expedited delivery orders can only be sent to a street address, not a P.O. Box. Expedited delivery affects shipping time, which will reduce the shipping time 1–2 days. Processing time may take 3–5 business days from the time ***MedImpact Direct*** receives your prescription.

I authorize ***MedImpact Direct*** to charge my credit card for any copayment, coinsurance, deductible, or any other amount owed on my prescriptions, including any applicable expedited delivery charges.

X Cardholder's Signature	Date

☐ Unless you check this box, we will keep this credit card on file to pay for any future orders or balance due. You can call ***MedImpact Direct*** to update this information at any time or you can update your payment preferences by logging into your account at www.medimpactdirect.com.

Authorizations

☐ Check here to request Easy Open Caps. Federal law requires that your prescription shall be dispensed in a container with a child-resistant or safety cap unless you request otherwise. If you would like your prescription with an Easy Open Cap, please check the box.

Pharmacy law may permit a pharmacist to substitute a less expensive, FDA-approved, generic equivalent medication for a brand name-medication unless you or your prescriber indicate otherwise.

By returning this form to ***MedImpact Direct,*** you verify that the information is correct, that the prescriptions enclosed are for eligible participants, and you consent to the release and use of the patient's health information to the patient's health plan(s) and healthcare providers/agents for health benefit management. ***MedImpact Direct's*** use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources, such as medical providers, shall be in accordance with federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

X Signature	Date

Mail this completed order form, along with your prescription and payment information, to:

MedImpact Direct, P.O. BOX 51580, Phoenix, AZ 85076-1580

Print

Revision 06.30.17
FL 880-2638 V11