Directions: Please print in **BLUE** or **BLACK** ink, using all **CAPITAL** letters.

Patient Profile and Prescription Order Form

Member Information

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) ____________________

ID Number (located on card) ____________________ Group Number ____________________

Last Name ____________________ First Name ____________________

Mailing Address ____________________

Physical Address (If different from Mailing Address) ____________________

City ____________________ State ______ Zip Code ____________

Please Complete

Allergies	Health Conditions
☐ Aspirin	☐ Arthritis
☐ Cephalosporin	☐ Asthma
☐ Codeine derivatives	☐ Diabetes
☐ Morphine derivatives	☐ Glaucoma
☐ Penicillin	☐ Heart disease
☐ Sulfa drugs	☐ Hypertension
☐ None known	☐ Pregnancy
☐ Other (use lines below)	☐ Thyroid disease
____________	☐ None known
____________	☐ Other (use lines at left)

I would prefer my prescription bottles to have easy open caps ☐YES ☐NO

Email-Address (to receive information regarding the processing of your order) ____________________ Home Phone ____________ Work Phone ____________ Cell Phone ____________

Preferred Method of Communication (if by phone, specify which number): ____________________

Additional Services Available: ☐ Auto Refill ☐ Text Message (when prescription is complete) ☐ Email Notifications (when prescription is shipped)

Cell Phone Carrier

☐ Verizon ☐ AT&T
☐ Sprint ☐ T-Mobile
☐ Other ____________

For text message notification only

Dependent Information

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) ____________________

Dependent Last Name ____________________ Dependent First Name ____________________

E-mail Address (to receive information regarding the processing of your order) ____________________ Alternate Phone ____________

Cell Phone ____________

Additional Services Available: ☐ Auto Refill ☐ Text Message (when prescription is complete) ☐ Email Notifications (when prescription is shipped)

Cell Phone Carrier

☐ Verizon ☐ AT&T
☐ Sprint ☐ T-Mobile
☐ Other ____________

For text message notification only

Please Complete

Allergies	Health Conditions
☐ Aspirin	☐ Arthritis
☐ Cephalosporin	☐ Asthma
☐ Codeine derivatives	☐ Diabetes
☐ Morphine derivatives	☐ Glaucoma
☐ Penicillin	☐ Heart disease
☐ Sulfa drugs	☐ Hypertension
☐ None known	☐ Pregnancy
☐ Other (use lines below)	☐ Thyroid disease
____________	☐ None known
____________	☐ Other (use lines at left)

I would prefer my prescription bottles to have easy open caps ☐YES ☐NO

Member Alternate Shipping Information

This is alternate shipping information for a member's medication. If a dependent's medication needs to be delivered to a different address, please specify below or contact m*i*Rx at 1-866-894-1496.

☐ This shipment only ☐ Temporary address change indicated to the right Start Date ____________ End Date ____________

Patient Name

____

Alternate Mailing Address

____

City ____________________ State ______ Zip Code __________ Alternate Phone Number ______________

Payment and Shipping Information

By submitting this form, you hereby authorize release of all information to m*i*Rx as required to process your order under your benefit plan. Please enclose your prescription with this form.

Total number of prescriptions this order............................ _____

☐ Regular Shipping..$ NO CHARGE
☐ Next Business Day ($19.00)........................$ _____ . _____
☐ 2nd Business Day ($12.00).........................$ _____ . _____

Total Shipping Cost..................................$ __________ . _____

Price of shipping may change by carrier without notification and may vary depending on weight and zone.

SEND TO:
MAIL: miRx, P.O. Box 21669, Billings, MT 59104;
EMAIL (scan form first): miRx@ebms.com or
PHONE: 1-866-894-1496
FAX: 1-406-869-6552

Payment Options ***(to pay over the phone, call 1-866-894-1496)***

☐ Check made payable to m*i*Rx
☐ Charge credit card listed below for this order only
☐ Charge credit card listed below for this and all future orders

☐ American Express ☐ Visa ☐ Discover ☐ MasterCard

Credit Card Number ______________________________

Expiration Date ______ / ______

PLEASE READ AND SIGN: I certify that the information provided on this form is current; and I authorize m*i*Rx Pharmacy to substitute generic drugs in all cases when legally permissible, in accordance with applicable law, consistent with my doctors order.

______________________________ ____________
Member/Cardholder Signature Date