MAILORDER PRESCRIPTION ENROLLMENT/CHANGE FORM

Please request mailorder prescriptions **10-14 days** before you need the medication. This allows time to contact your MD or insurance provider if needed. During the holidays, mail volume is often increased. Please be aware that mail is not delivered on post office holidays. All controlled substances are mailed certified mail and will require a signature upon receipt.

CHECK BOX THAT APPLIES **NEW ENROLLMENT** ☐ **CHANGE** ☐

PRIMARY CARD HOLDER INFORMATION (MUST BE FILLED OUT WITH ALL CHANGES)

Name:_____ **Birth Date:** _____

Drug Allergies: _____ **Insurance Number:** _____

Mailing Address: _____

City:_____ **State:** _____ **ZIP Code:**_____

PHONE: Home( ) _____ **Cell( )** _____ **Work( )**_____

Safety Caps: Yes or NO (*Please Circle One***)**

Email address for delivery confirmations and tracking information:_____

I give Mail Order Pharmacy authorization to place my prescriptions for myself and my dependents on automatic refill. I will be responsible for contacting Mail Order if there are any discontinuations in medications before they are processed. I also understand that if I decline for automatic refill, that it will be my responsibility to contact Mail Order for any refill requests, including new prescriptions. YES NO (*please circle one*)

List any dependent family members, date of birth (DOB), and allergies for each person ON Insurance

1. (___/___/___) Allergies
2. (___/___/___) Allergies
3. (___/___/___) Allergies
4. (___/___/___) Allergies
5. (___/___/___) Allergies
6. (___/___/___) Allergies

Credit Card Payment ❑ Visa ❑ Mastercard ❑ Discover

❑ Circle one: **Debit** **Credit Card**

Cardholder Name

Card #:___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ CVV code: ___ ___ ___ ___

*Expiration Date (MM/YYYY)*_____

Cardholder Signature:_____**Date**_____

I authorized Mission Pharmacy-Employee Mailorder to bill my credit/debit card for this and all future orders at the time my order is filled..

Payroll Deduction MISSION EMPLOYEES ONLY

Employee Name _____

Employee 7 Digit ID and Department _____

Important information about Payroll Deduction:

I hereby authorize the Payroll Department to deduct from my pay for prescriptions filled at my request by Mission's Mailorder Pharmacy for up to a 90-day supply of medication. My signature below acknowledges that this is a non-refundable payroll deduction. In the event of resignation/termination of my employment, any balance still remaining from this payroll deduction will be subtracted from my final paycheck.

Employee Signature:_____**Date**_____

AUTHORIZATION

By signing below, I certify that the information on this form is correct, and I authorize the release of information regarding my Medical and prescription drug history to Mission Mail Order Pharmacy.

Patient Signature:_____**Date**_____

Email, Mail, or Fax Completed Form along with copies of other prescription insurance information to

Mission Pharmacy – Employee Mailorder – 400 Ridgefield Court, Suite 106, Asheville, NC 28806

Phone (828) 257-7057 // Fax (828) 257-7059// NCDV.MailOrderPharmacy@hcahealthcare.com

We regretfully cannot accept faxed or photocopied prescriptions from patients.