BlueCross BlueShield of South Carolina

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BlueCross BlueShield of South Carolina Mail Service Order Form

For more information, visit our Web site at **www.SouthCarolinaBlues.com** or call **1-888-963-7290**.

Instructions: Please PRINT in CAPITAL letters using BLACK ink only. Fill in the applicable ovals completely (●). Mail this completed form, the doctor's signed prescription(s), and your payment to Caremark in the envelope provided.

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Rev. 11/04

1 Member Information/ Health History

Member Identification Number *(refer to your insurance card)*

Member Name *(Last Name)* *(First Name)* *(MI)*

Delivery Address *(if you select 2nd Day or Next Day shipping, fill in a street address, not a P.O. Box)*

City **State** **Zip**

Daytime Phone Number

( ) –

Above delivery address is: ○ *For this order only* ○ *For this and all future orders*

E-mail Address *(Optional)*

Providing your e-mail address and phone number authorizes us to contact you about your Caremark account or our services. This information will not be shared with any outside party. If other household members also use this e-mail address, they may be able to access your health information.

Mark all allergies or conditions that apply to you, your spouse or covered dependents by completely filling in the oval below that description. Contact your doctor if you are unsure about any health conditions. This information will not be required on future order forms unless there has been a change in health status.

	Birthdate M M D D Y Y Y Y	Male/Female (M / F)	**No Known Allergies**	Penicillin Allergy	Sulfa Allergy	Other Allergy	Diabetes	Thyroid	Heart Condition	High Blood Pressure	Ulcers	Epilepsy	Glaucoma	Other Conditions *(Please list below)*
Member's First Name			○	○	○	○	○	○	○	○	○	○	○	○
Spouse's First Name			○	○	○	○	○	○	○	○	○	○	○	○
Dependent's First Name			○	○	○	○	○	○	○	○	○	○	○	○
Dependent's First Name			○	○	○	○	○	○	○	○	○	○	○	○

Please list first name and then detail "other conditions" referenced above _____

_____

List any non-prescription medications that you take on a regular basis or prescription medications that you obtain without using your insurance card: _____

_____

_____

Mail your prescriptions to: Caremark • P.O. Box 830070 • Birmingham, AL 35283-0070

2 New Prescription Information

Enclose original doctor-signed prescription(s) and payment with this form. Ask your doctor to write your mail order prescription for the maximum supply allowed by your plan (if appropriate).

Prescriptions are for: ○ Member ○ Spouse of Member ○ Dependent(s)

Total number of medications in this order:

Doctor Name *(Last Name)* *(First Name)*

Doctor Phone Number

( ) –

○ Prescription Bottle Cap: A child-resistant cap is included with every order. Mark here if you would also like an easy-open cap.

○ Caremark may contact your doctor regarding your prescription. This may result in your doctor prescribing a different clinically-appropriate product in place of your original prescription. If you do not want your doctor contacted about a preferred, potentially cost-saving product, mark here.

○ **¿Quiere las instrucciones en español? (Spanish label instructions?)**

Generic Medications: We want to provide you with high quality medications at the best possible price. In order to do this, we may occasionally contact your doctor to obtain authorization to dispense the generic version of your brand-name drug. Receiving generics often results in savings to you. No change to a generic will be made without the consent of your doctor. If you do **not** want us to substitute a generic, when appropriate, please list the drug name(s) below that you do not want us to substitute.

Drug Name(s) 1. _____ **2.** _____

3. _____ **4.** _____

3 Shipping/ Payment Information

Your order will be shipped standard delivery at no charge. Please allow 14 days from the date you mail your order for delivery of your medicine. If you prefer expedited delivery, mark the appropriate oval. Expedited shipping only affects shipping time, not processing time of your order.

○ **2nd Business Day = $10** (per order)

○ **Next Business Day = $15** (per order)

All medications in this order will be sent in the same package to the address provided. If a family member does not want his or her medicine sent in the same package as that of other family members, he or she should complete a separate order form.

Payment, when applicable, is due with each order and may be made by credit card or check. Payment by credit card is preferred. If paying by check, make the check payable to Caremark. Please write your member identification number on your check. There is a $20 returned check charge. **Do not send cash.** Orders received without payment may result in a delay of processing.

Any outstanding balances will be the responsibility of the primary insured.

If you have questions about your payment amount, call the phone number printed on the front of this form.

○ Credit Card (provide information below) ○ Payment by Check or Money Order

○ MasterCard ○ Visa ○ Discover ○ American Express ○ If you want all future orders to be billed to this card, mark here.

Credit Card # **Exp. Date** (MM-YYYY) –

Credit Cardholder Signature _____

The credit card will be charged for drug costs, expedited shipping (if applicable) and any outstanding balances due.

By returning this form to Caremark, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management.

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