

PLEASE FILL OUT THIS SIDE OF CARD COMPLETELY IF YOU HAVE ELIGIBLE DEPENDENTS

If an eligible dependent in your family has any drug allergies, medical conditions, is sensitive to any drugs, or is pregnant, list below. If you have no eligible dependents, check here -

Spouse

Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

Dependents

1. Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

2. Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

3. Name _____ Male
 Female
 Drug Allergies _____ Date of Birth _____
 Medical Condition _____ Doctor's Name _____

PLEASE FILL OUT SECTION BELOW IF YOU WANT US TO CONTACT YOUR PHYSICIAN

Medication Name	Strength	Quantity	Prescription Directions	Doctor Information			Patient	
				Name:	Phone:	Fax:	Fill Now	Fill Later
				Name:				
				Phone:				
				Fax:				
				Name:				
				Phone:				
				Fax:				
				Name:				
				Phone:				
				Fax:				

DRUGSOURCE, INC.

Home Delivery Service

A PROGRAM FOR PRESCRIPTION AND NON PRESCRIPTION ITEMS

ENJOY THE CONVENIENCE OF

- Shopping from home
- Home delivery
- Mail order is cost effective when compared to local pharmacy
- Toll free number available 24/7
- We can contact your doctor for refill authorization
- Doctor can phone or fax in orders
- Pharmacist available 24/7 for consultation
- Prescriptions processed within 24-48 hours of receiving
- Receive shipping confirmation when you provide your email address

Orders Can Be Placed By:
Mail Phone
Fax Email
New Rxs can be faxed from MD only

DRUGSOURCE, INC.
 P O BOX 1366
 ELK GROVE VILLAGE, IL 60009-1366
 (800) 854-8764
 Fax (847) 258-1913
 www.drugsourceinc.com

How To Order

- Before leaving your doctor's office:
 - If you need medication on a long-term, regular basis (called maintenance medication), ask your doctor to prescribe up to a 90-day supply. **DRUGSOURCE, INC.** will only dispense the amount of medication that your doctor has prescribed up to a 90-day supply.
 - Discuss generics. Ask your doctor to prescribe generic medication whenever possible. **DRUGSOURCE, INC.** will fill your order with a generic drug, if one is available, if both you and your doctor agree to a generic substitution.
 - If you already have a prescription, make sure it clearly shows your doctor's name and address, exact dosage and patient's name. Please print the patient's name and date of birth on the back of each prescription.
- DRUGSOURCE, INC.** will accept a personal check, money order or major credit card. Remember to complete the Patient Profile Form and enclose the form with the appropriate co-payment and original prescription(s) in the return reply envelope. **DO NOT SEND CASH.** If using a credit card, please include your card number and expiration date with your order.

Please Note: According to Illinois State Law, if you are using a Schedule II narcotic such as Ritalin, Adderall, Concerta, Duragesic patches, etc., you need to submit a written prescription to us within seven (7) days from the date written on the prescription. Some states don't allow an out of state pharmacy to fill Schedule II prescriptions, or may restrict quantities.

CUT ALONG DOTTED LINE

****Shaded Fields Must Be Filled IN** DRUGSOURCE, INC. PATIENT PROFILE FORM**

COMPANY NAME _____	GROUP NO. _____	<input type="checkbox"/> Check here if new address
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E-Mail Address for shipping confirmation _____

For your safety, we maintain a Patient Profile Record, so please complete both sides and return with your order.

Employee's Name (Please Print) _____		
First	Middle Initial	Last
Address _____		Phone () _____
Street	Apartment Number	
City	State	ZIP

Shipping Address if different _____

Employee's Date of Birth ____/____/____ Male Female Are you pregnant at this time? Yes No

Describe employee's drug allergies and medical conditions: _____
 Check here if none:

Print name of Physician ordering medication: _____

Physician's Telephone Number: _____ Physician's Fax Number: _____

Employee's I.D. Number: _____

I authorize DrugSource to dispense generic medications. Yes No

Would you like a call from a Pharmacist to discuss any medical questions that you may have? Yes No

I understand that refusal of generic medications may impact my co-payment.

(Signature Required) X _____

When ordering a refill of a prescription previously filled by DRUGSOURCE, INC, use the below lines to list the Rx number(s) and the medication name(s) found on the bottle label.

_____/_____/_____/_____

_____/_____/_____/_____

Amount of co-payment enclosed \$ _____	<input type="checkbox"/> Check Enclosed (\$20 returned check service charge will apply)
Please charge my credit card <input type="checkbox"/>	<input type="checkbox"/> VISA <input type="checkbox"/> MASTER CARD <input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> DISCOVER
Credit card number _____	Expiration date _____

CERTIFICATION STATEMENT

IMPORTANT: I certify that all information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, and sponsor in accordance with the Health Insurance Portability and Accessibility Act (H.I.P.A.A.).

Employee's Signature X _____ Date ____/____/____