Prescription Solutions® Mail Service Pharmacy · Prescription Order Form

UnitedHealthcare
A UnitedHealth Group Company

Confidential Patient Profile. Please complete and return with your prescription order.

Please print in black or blue ink.

Member ID #

Plan

Date of Birth — —

Gender ☐ F ☐ M

Last Name

First Name

MI

Delivery Address

City

State

Zip —

Phone Number - -

Email Address:

Doctor Name (Last, First)

Doctor Phone Number - -

Health History

Please complete if not reported previously or a change has occurred.

Allergies:

☐ No Known ☐ Sulfonamides/Sulfa ☐ Penicillin ☐ Erythromycin ☐ Cephalosporins

☐ Aspirin ☐ Ampicillin ☐ Tetracycline ☐ Quinolones

☐ Codeine ☐ Other (please specify): _____

Health Conditions:

☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Glaucoma ☐ Heart Condition

☐ High Blood Pressure ☐ High Cholesterol ☐ Osteoporosis ☐ Thyroid Problems ☐ Cancer

☐ Other (please specify): _____

Please list any Over The Counter or Herbal Medications you take regularly: _____

Special Instructions

In order to provide you with high quality medications at the best possible price, we substitute FDA-approved generic equivalents for brand name medications whenever possible. Generic medications will not be sent if your doctor indicates a brand name medication should be dispensed. **If you require a brand name medication for this order, please check the box below and list all medication names*:**

☐ _____

*Brand name medications may be subject to a higher cost.

Payment & Shipping Information

Do Not Send Cash

Standard shipping of your order is free and most are shipped by the U.S. Postal Service. Please note, the shipment method will not expedite processing time. If you require a faster shipping method for this order, please indicate below.

☐ **Use credit card on file**

☐ **Overnight Shipment Method** - Add **$12.50** to order amount

☐ **Use enclosed check for payment**
All checks must be signed and made payable to Prescription Solutions

☐ **Use credit card for payment: (Visa, MasterCard, Discover, American Express)**

Credit Card Number:

Exp. Date (month/year) /

Signature: _____

This credit card will be billed for medicine costs, expedited shipping (if applicable), and any outstanding balances. It will also be billed for all future orders, unless you provide a different form of payment. Payment in excess of amounts due will be credited to your Prescription Solutions account. If method of payment is not indicated, Prescription Solutions will apply the charges to the credit card on file.

Send via U.S. Mail to: Prescription Solutions, P.O. Box 509075, San Diego, CA 92150-9075
Be sure to include this order form and your original prescription(s). Please call 1-800-562-6223 with any questions.
Visit our Web site at www.myuhc.com