



Registration and Prescription Order Form

33381 Walker Road • P.O. Box 166 • Avon Lake, OH 44012-9927
Telephone: 1-800-763-0044 • Fax: 1-800-893-2299

Please complete this form and return it along with your prescriptions in the enclosed envelope to: Immediate Pharmaceutical Services, Inc., P.O. Box 166, Avon Lake, Ohio 44012-9927. Your order will be processed within 48 hours after receipt and will be mailed via UPS or U.S. Mail.

Member Information

Male/Female:	Date of Birth:	Member ID Number (located on card):
Suffix (if on card):	Group Number:	
Employer Name:		
Last Name:		First Name:
Daytime Telephone:	Evening Telephone:	
E-mail Address (to receive information regarding the processing of your order):		
Permanent Address 1		
Permanent Address 2		
City, State & Zip		

Other Dependents Eligible For Prescription Drug Program (please print)

Spouse	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 1	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 2	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 3	First _____	MI _____	Last _____	DOB _____	Sex _____

Please Complete the Health Profile for Each Dependent

Allergies	Member	Spouse	Dependent 1	Dependent 2	Dependent 3	Health Conditions	Member	Spouse	Dependent 1	Dependent 2	Dependent 3
Aspirin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cephalosporin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Codeine derivatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Morphine derivatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Penicillin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sulfa drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Erythromycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Seizure Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None known	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
						None known	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Allergies:						Other Health Conditions:					
Member _____						Member _____					
Spouse _____						Spouse _____					
Dependent 1 _____						Dependent 1 _____					
Dependent 2 _____						Dependent 2 _____					
Dependent 3 _____						Dependent 3 _____					

If a dependent's medication needs to be delivered to a different address, please submit information on a separate sheet of paper or call 1-800-763-0044. I have attached additional address information



PRESCRIPTION FAX FORM

33381 Walker Road • PO Box 166 • Avon Lake, Ohio 44012

FORM INSTRUCTIONS

PATIENT INSTRUCTIONS: In all cases, you should obtain a new written prescription from your physician and mail it to us with the enclosed Registration & Prescription Order Form. If this is not possible, follow these steps to have your physician submit your prescription directly to IPS:

1. Complete the sections below using black ink only
2. Have your doctor fill out the specific prescription information
3. Have your doctor fax the completed form to Immediate Pharmaceutical Services, Inc., (IPS), at 1-800-893-2299
4. Allow 2 weeks for delivery

NOTE: The prescription form must be faxed from your doctor's office in order to be valid.

Please ensure you have a credit card on file for the processing of payment for your order. By having your physician submit this form, you are authorizing IPS to charge your card. If you are unsure of the copayment for the following prescription, you may obtain prescription copayment information in advance, by calling 1-800-763-0044.

Physician Name: _____

Faxed By: _____

Physician Telephone #: _____

Physician Fax #: _____

IPS Telephone: 1-800-763-0044 (Option "7" for a Pharmacist)

IPS Fax: 1-800-893-2299

By providing this form, you have authorized release of all information to Immediate Pharmaceutical Services, Inc., as needed to process your prescription and refills.

PRESCRIPTION INFORMATION

Physician Name: _____

Office Telephone: _____

Patient Name: _____

Patient Telephone: _____

Member ID #: _____

Patient DOB: _____

This section is to be completed by the prescriber.

Medication Name: _____ Strength: _____

Quantity: _____

Directions: _____

Refills: _____

MD Signature: _____

DEA Number: _____ Date: _____

PHYSICIAN INSTRUCTIONS: Please FAX completed form back to IPS pharmacy.

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.