Mail Order Registration Form

Integrated IHMO Pharmacy®

Follow the four steps on the front and back of this form and you'll be registered for home delivery of your prescription medications, which can save you substantial time and money.

1: Provide your background information

Plan Information

Plan Name	Member ID Number	Group Number (if Known)

Patient Information

☐ Please, no child-proof caps

First Name		Last Name	
Birthday	**Sex**	**Email***	

**Integrated HMO Pharmacy may choose to communicate with you via email if you provide a valid email address. We value your privacy. Your personal information will be kept confidential and will never be sold to third parties. It will only be used for communications you request related to the services provided by IHMO Pharmacy.*

Shipping Information

☐ Check this box if this is a change of address

Street Address		Apt. or Suite	City
State	**ZIP Code**	**Home Phone Number**	**Work Phone Number**

Physician Information

First Name	Last Name	Physician's Phone Number

Allergies

☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Sulfonamides
☐ None
☐ Other: _____

Health Conditions *(to monitor drug/disease interactions)*

☐ Arthritis
☐ Diabetes
☐ Glaucoma
☐ Heart Condition
☐ High Blood Pressure
☐ High Cholesterol
☐ Intestinal Disorder(s)
☐ Lung Condition
☐ Thyroid
☐ Other: _____

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the prescription drug program and authorize the release of all information to the plan administrator. I certify that I do not have primary prescription coverage under another plan. If the prescription coverage is denied, I agree to reimburse Integrated HMO Pharmacy for the amount of benefit which is being denied under the prescription plan.

Insured's Signature	Date

Questions?
Call 1 (800) 633-7928
TTY: (866) 706-4757

Form continues on back >

Visit ihmo.pti-nps.com

2: Provide your payment information

Payment Information

VISA, MasterCard, and Discover are accepted. You may also pay with a check, cashier's check, or money order. However, IHMO must receive your copayment before shipping any order. If you choose to use a credit or debit card, IHMO Pharmacy can keep your information on file for your purchases.

□ Credit Card □ Debit/Bank Card	□ Authorize this card for all future payments □ Call me to authorize this card before filling each order

I understand that all copayments and/or prescription costs for products purchased through Integrated HMO Pharmacy will be charged to the credit card provided above. I also understand by signing this form that prescription medications cannot be returned to the pharmacy for credit unless in response to a recall, defect in a medical device, or otherwise pre-approved by the pharmacy. A medication return for any reason will result in its immediate destruction and shall not be available for credit.

Credit Card Number	Expiration Date
Name as it Appears on the Card	
Billing Address	
Signature of Cardholder	Date

3: Check your work

Make sure the information on this form is correct. This information will remain private, and will be used to fill your prescriptions and monitor for any harmful drug/disease interactions.

4: Submit this form

Either fax the form to **1 (800) 801-2395** or mail the form to:

Integrated HMO Pharmacy
PO Box 369
Boys Town, NE 68010

If you ever have a question about your medications, shipments, or billing, IHMO Pharmacy's U.S.-based support specialists and pharmacists are available by phone.

Call 1 (800) 633-7928 TTY: (866) 706-4757

To get your new prescriptions filled...

Mail: You may mail an original prescription from your doctor. Ask for your prescription to be written for a 90-day supply, and for up to a year of refills to make getting your medications as easy as possible. Order forms for refills will be included with each order you receive.

Fax: Prescriptions may be faxed to 1 (800) 801-2395 from the prescribing physician's office. The fax must include a fax cover sheet from the physician's office.

Phone: Have your Rx numbers (found on your bottle or prescription reorder form) ready and then call 1 (800) 633-7928. You may leave a message with the prescription refill center. Be ready to leave the patient name, date of birth, contact information, and any special requests.

ePrescribe: Your doctor may submit your prescription to IHMO Pharmacy via electronic prescription. Have them call 1 (800) 633-7928 with any questions.

Quantities to be dispensed: Have your physician write your prescription for a three month or a 90-day supply; the prescription must display the exact quantity to be dispensed by IHMO Pharmacy.

ATTENTION: National Pharmaceutical Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-546-5677 (TTY: 1-866-706-4757).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-546-5677 (TTY: 1-866-706-4757). // National Pharmaceutical Services cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-546-5677（TTY：1-800-546-5677）。 // National Pharmaceutical Services 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。