DRUGSOURCE, INC. Mail Order Pharmacy

OBTAIN A PRESCRIPTION FORM

Please mail to: DrugSource, Inc.
PO BOX 1366
Elk Grove Village, IL 60009
Toll Free: 800/854-8764 Fax: 847/258-1913

1 Patient Information:

Complete one form for each family member. We will contact your physician to obtain the prescription(s).

Insurance Information* *Found on your prescription benefits/insurance card

Company Name :	Group # :
Member/Patient ID Number :	Bin # :

Patient's Name : _____
First Last

Address : _____
Street Apt #

_____
City State Zip Code

Phone # : (_____)_____ DT Phone # : (_____) _____

Birth Date : _____ Gender : ☐ Male ☐ Female
MM / DD / YYYY

Shipping Address, if different:

_____
Street Apt #

_____
City State Zip Code

Alt Contact # : (____) _____

Physician Name : _____

Physician Phone : (_____)_____ Physician Fax : (_____)_____

Employee Allergies/Medical Conditions (write none, if none) :

_____

_____

List Prescriptions (RXs)/OTC Medication you are currently taking (including RXs DrugSource has not filled):
Attach additional paper, if necessary. _____

_____

2 Prescription Information:

Please provide the information below for DrugSource to send a request to your physician.

Medication Name	Med Strength	Med QTY	Prescription Directions	I will contact Drugsource when needed	Please fill now

3 Payment Information:

Check the box to choose the type of payment you would like to use for your orders.

☐ Electronic Check. *Include a voided check or its copy*

☐ Check or Money order. *Make checks/money orders payable to DrugSource, Inc.* **Check # _____** **Amount $ _____**

☐ Credit Card/Debit Card ☐ *VISA* ☐ *MASTERCARD* ☐ *DISCOVER* ☐ *AMER. EXPRESS*

☐ Use Credit Card on file

☐ This is a new credit card/updated credit card & expiration date _____ - _____ - _____ - _____ **Exp Date ____ /____**

Please Provide Security Code _____

☐ Yes, I authorize DrugSource to dispense generic medications.

☐ No, I do not authorize DrugSource to dispense generic medications. I understand that refusal of generic medications may impact my co-payment.

☐ I would like a call from a pharmacist to discuss questions I may have.

☐ Please send me an email notice when my package is shipped.

☐ Please correspond with me about my orders through email.

Email _____

Signature X _____ Date _____