



Medica Medicare SolutionsSM

The source
for all of your
pharmacy needs.

MEDICA[®]

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Conveniently order all of your pharmacy needs online
at our own Internet pharmacy, www.ScripPharmacy.com.

online drug information

ask the pharmacist

refill prescriptions

Ready to place an order? It's easy!
Either fill out the attached patient profile form
and enclose it with your actual prescription
in the postage-paid envelope, being sure
to indicate whom the prescription is for;
or
Go to www.ScripPharmacy.com, create
an account and enter in your prescription
order online through our simple 3-step
ordering process.
If at any time you have questions while
trying to place an order, call ScripPharmacy's
Customer Service at **1-800-677-4323**, 24 hours
a day. TTY callers: **1-877-517-9301**.

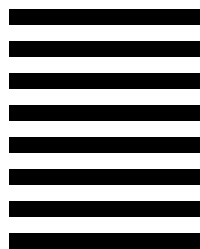
Need a refill?
After you have placed your first order and are ready
for a refill, you can do one of the following:
- order your refill at www.ScripPharmacy.com
- call our 24-hour refill line at **1-800-926-2455**
and be sure to have your Rx number available
- mail us the [prescription reorder form](#) in the
postage-paid envelope that came with your
last order
Additionally, once you have ordered through
ScripPharmacy and we have your account on file,
you can direct your doctor to our special physician
lines. Your doctor can fax your prescription to
1-800-205-7408 or call it in to **1-800-677-4323**.

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 5384 COLUMBUS OH

POSTAGE WILL BE PAID BY ADDRESSEE



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



ScripPharmacy
Dept C
PO Box 1778
Columbus OH 43272-5410



ScripPharmacy is a valuable component of your prescription benefit. Why? Because by using **ScripPharmacy**, you'll receive certain advantages that only mail service has to offer. Try it and you'll see!

- Order up to a 3-month supply of your medication
- Put an end to waiting in long lines at your local pharmacy
- Avoid having to remember to reorder your prescription every month
- Have your medication shipped directly to your home, office or vacation spot
- Take advantage of our Customer Service department available to assist you 24 hours-a-day at **1-800-677-4323**.
- Choose from convenient ordering options: phone, Internet, fax and mail
- Please check your Evidence of Coverage to verify your day supply limits

Ask your doctor for a 3-month supply prescription.

Why does it benefit you to request a 3-month supply?

You won't have to place your order over and over again each month. Instead, order just once every three months.



Request a generic.

Next time your doctor writes you a prescription, ask if a generic version of the drug is available. Generic drugs are safe, and choosing them saves you money.

HCSPH001

DETACH, MOISTEN, FOLD OVER AND SEAL ENVELOPE SO THAT THE MAILING PANEL SHOWS

(FOLD THIS PANEL DOWN FIRST, THEN THE BOTTOM PANEL UP)

(FOLD THIS PANEL DOWN FIRST, THEN THE BOTTOM PANEL UP)

This information is required by federal and state law, and will be used exclusively by the pharmacists of ScripPharmacy in order to more effectively manage your prescription drug therapy. All information is considered confidential.

Patient Profile: Health Conditions

Acne	Anxiety	Arthritis	Asthma	Heart Condition	High Blood Pressure	Glaucoma	HIV/AIDS	Epilepsy

Please check all boxes that apply.

Patient Profile: Drug Allergies

Aspirin	Codeine	Penicillin	Sulfa	None

Please check all boxes that apply.

Other Allergies: _____

Other Health Conditions: _____

Other Medications Being Taken: _____

Please list names of all physicians providing care (include dentists, podiatrists, eye doctors, etc.) and their telephone numbers:

Physician Name	Physician Phone	Specialty

(MOISTEN AND SEAL)

(MOISTEN AND SEAL)

(If you need additional space, please enclose a separate piece of paper.)

I certify that the information on this form is correct, and authorize release of all information regarding my family's or my own medical and prescription drug history and treatment to the Plan Sponsor and to ScripPharmacy.

Signature: _____ Date: _____

TO ORDER BY MAIL:

Complete this form and the patient profile on the reverse side. Detach and return along with your prescriptions and co-payment in the attached envelope.

Insured's Name: _____ Member ID #: _____

Plan Name: _____

Social Security Number: _____

Group Number: _____

Ship to: CHECK HERE IF NEW ADDRESS OR PHONE NO.

Home Ph. (____) _____ Daytime Ph. (____) _____

Address: _____

City: _____ State: _____ ZIP: _____

Number of Rx's Enclosed _____ X _____ Co-pay = \$ _____

Check or money order enclosed (make payable to ScripPharmacy)

Bill my credit card: Amex Visa MasterCard Discover

Card Number: _____ Exp. Date: _____

Cardholder Signature: _____

Prescriptions Enclosed For: _____ Number of Rx's Enclosed: _____

Name: _____ ID #: _____

(MOISTEN AND SEAL)

(MOISTEN AND SEAL)

Sex: Male Female

Do you have access to the Internet?
 Yes No

Would you like our pharmacists to e-mail you health news and promotion information?
 Yes. My e-mail address is: _____