MAXOR PHARMACIES℠

Mail Service Request Form

This form is used to order refills or new prescriptions. Please mail this form 14 days in advance before your medication runs out and enclose the appropriate copayment amount.

For Office Use:

NP CC_____ CK#_____ Amt_____

Patient Information

Name: _____ D.O.B.: _ _ / _ _ /_ _ _ _

Address: _____ Sex: ☐M ☐F

City, State, Zip: _____

Phone# Day: _____ Evening: _____ E-Mail: _____

Cardholder ID #: _____ Rx Group #: _____

☐ Check here if this is a change of address. Will this be a temporary address change? ☐ YES ☐ NO

☐ Please no child-proof caps *(By requesting easy open caps, I acknowledge and agree to release Maxor Pharmacies from any and all obligations to provide child resistant packaging under the Poison Prevention Act.)*

PHYSICIAN INFORMATION & MEDICAL HISTORY

Primary Care Doctor: _____

Physician's Phone #:_____

Current Medications (including over-the-counter):_____

_____

_____

_____

Drug Allergies:

☐ None ☐ Codeine

☐ Sulfa ☐ Aspirin

☐ Penicillin ☐ Other_____

Medical Conditions / Diseases:

☐ Thyroid ☐ High Blood Pressure

☐ Diabetes ☐ Glaucoma

☐ Heart Condition ☐ Intestinal Disorders

☐ Lung Condition ☐ Other_____

ENCLOSE CORRECT CO-PAY PER PRESCRIPTION

Please refer to your plan benefit information booklet or your insurance card for co-payment amounts. You may call for assistance with calculating your co-payment.

Payment Method:

☐ **check/money order**

☐ **VISA** ☐ **MasterCard** ☐ **Discover**

☐ **American Express**

Credit Card# _ _ _ _ / _ _ _ _ / _ _ _ _ / _ _ _ _

***CID** _ _ _ Exp. Date ___ / ___

**Required Information. CID: Card Identification Data follows the card account on the signature panel.*

Signature_____

☐ Check to decline keeping credit card information on file at the pharmacy

How to Order Refills

BY MAIL: Complete the Patient Information, Payment Method, and Order Refill sections and mail to Maxor Pharmacies Mail Service.

BY PHONE: Call toll free 1-800-687-8629 or (806) 324-5500 and use our automated system to enter the Rx number printed on your prescription label, or speak to a customer service representative during normal business hours.

BY INTERNET: www.maxor.com

Order Refill Prescriptions Here:

Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

Important Information

The submission of the form, for you or any of your dependents, authorizes the release of all information to the Plan Sponsor, Administrator, or Underwriter, and authorizes the prescription to be filled with the generic equivalent when available and permissable by law, in accordance with your benefit plan requirements. If you request a brand name drug when your doctor permits substitution, you may be responsible for paying the difference in cost between the brand and generic medication plus the brand co-pay. Refer to your plan benefit information booklet for more details.

- ***Please note:***

If your prescription refill label says "NO REFILL AUTHORIZED," please contact your doctor and request a new written prescription.

Mail your order to the following location:

P.O. Box 32050
Amarillo, Texas 79120

Call Us Toll Free At

1-800-687-8629

or (806) 324-5500 (Amarillo Area)

Monday - Friday 8 a.m. to 6 p.m. CST

Written information about this prescription has been provided for you. Please read this information before you take this medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer your questions. Please call your pharmacy.

Complaints against the practice of pharmacy may be filed with the:

Texas State Board of Pharmacy
William P. Hobby Building, Suite 3-600
333 Guadalupe, Box 21
Austin, Texas 78701-3942 (512) 305-8000
To receive a complaint form call
800/821-3205 or 305-8080 if in Austin.
(recorded information only)
www.tsbp.state.tx.us

Se la presentado a usted la informacion por escrito sobre esta receta. Favor de leer esta informacion antes do tomar el medicamento. Si usted tiene preguntas tocante a esta receta, estara un farmaceutico disponible durante las horas de negocio para contestar sus preguntas. Por favor llame a su pharmacia.

Quejas contra la practica de la farmacia pueden ser reportadas al:

Concilio de Farmacia Del Estado De Tejas
William P. Hobby Building, Suite 3-600
333 Guadalupe, Box 21
Austin, Texas 78701-3942 (512) 305-8000
Para recibir una forma de queja llame:
800/821-3205 o 305-8080 en Austin.
(informacion grabada solamente)
www.tsbp.state.tx.us

Patient Information Mail Order Form

Welcome to the Mail Service Prescription Program Maxor Pharmacies is providing for your company.

- This program offers a convenient, cost effective way to order prescribed long-term medication for direct delivery to your home. We are pleased to extend this service to you and look forward to fulfilling your prescription needs in the future.
- For **NEW** prescriptions or first time orders, complete the Patient Information and Payment Method sections. Write the member identification number on the back of all original prescriptions and mail to Maxor Pharmacies Mail Service.
- To **REFILL** prescriptions through the mail, complete the Patient Information, Payment Method, and Order Refill sections and mail to Maxor Pharmacies Mail Service for processing.

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