

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

Patient's relationship to member

M F

Self Spouse Dependent Domestic partner

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

Patient's relationship to member

M F

Self Spouse Dependent Domestic partner

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan, plus refills for up to 1 year, if appropriate (not a 30-day supply, plus refills).

Complete a patient/doctor section for *each* person with a prescription.

Be sure you have filled out the Health & Medication Questionnaire.

Unpaid balances

If your plan limits the balance that you can carry on your account and you exceed that limit with this order, payment must be included. To price a medication, visit us online at **www.medco.com** and click "Price a medication." To avoid processing delays, call Member Services to enroll in our e-check program or provide a credit card number in the "Complete your order" section on side 1.

Generic substitution

Texas, Florida, and Ohio laws allow a generic equivalent drug to be substituted for certain brand-name drugs, unless you or your physician specifically directs otherwise. Ask your doctor or pharmacist whether safe, effective, and less expensive generic drugs are right for you. Or, call Medco at the number

on your member ID card and ask to speak with a pharmacist. Pharmacists are available 24 hours a day, 7 days a week, to answer questions concerning your prescription.

If you live in Texas, you have a right to refuse generic substitution. In many cases, choosing a brand-name product will result in a higher co-payment. **Check the box if you do not want a less expensive, generic version of your medication.** Please note that this only applies to this prescription and future refills of this prescription.

If you have Medicare Part B coverage

Medco does not submit prescription drug claims to Medicare Part B. Check your Medicare Part B coverage to determine whether Medicare Part B covers your prescription(s) **and** whether it will cost you less to use a Medicare Part B participating pharmacy. For a list of Medicare Part B participating pharmacies, call your local Medicare carrier or call **1 800 MEDICARE (1 800 633-4227)**. For questions about your Medco-administered coverage, please call Member Services.

If you need additional information or assistance, visit us online at **www.medco.com** or call Medco Member Services.

Mail your prescription(s) (and refill slips), all forms (order form and the e-check enrollment form and Health and Medication Questionnaire, if applicable), and your payment in a standard business envelope to the appropriate mail-service pharmacy. You'll find the address online in the "Forms and cards" section of our website, **www.medco.com**. **Do not use staples or paper clips.**

Health, Allergy & Medication Questionnaire (HMQ)



Your answers to the following questions will help us provide your prescription drug benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each person in the household eligible for prescription drug benefits with Medco By Mail.
- If you need additional forms you may copy this form or call your toll-free Member Services number.
- **Please remember to print your group and member number on both pages.**
- **Return this questionnaire with your prescription or refill order form.**

Section 1: Member Identification and Contact *(Group and Member number required on all pages)*

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Group Number

Member Number *(Located on your pharmacy benefit card and/or in your benefits information)*

Daytime Telephone Number

	M.I.	
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Member/Subscriber First name

Last Name

Street Address/Apt No.

City

State

Zip

Section 2: Drug Allergy Conditions

For each covered family member, include their first name, date of birth and gender.

For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past.

If your allergy is not listed, please print only the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: ● **Please use blue or black ink.**

<i>Please add last name if different than member First Name:</i>	Member	Spouse	Dependent	Dependent	Dependent
Date of Birth (MM/DD/CCYY):					
Gender:	O M O F	O M O F	O M O F	O M O F	O M O F
Penicillin/cephalosporin Antibiotics (e.g. ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g. Tylenol #3®)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, Advil®, Motrin®)	○	○	○	○	○
Aspirin (e.g. salicylates)	○	○	○	○	○
Sulfa drugs	○	○	○	○	○
Iodine	○	○	○	○	○
If there is a drug allergy to report and not listed above, please print only the name of the drug in the space. Example: <i>Morphine</i> →					

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Please continue on next page to tell us about any medical conditions.

Group Number

Member Number

Section 3: Medical Conditions

Please list names of each family member enrolled in the appropriate column. Then for each family member, fill in the circle next to each condition if a doctor ever said *that particular family member* has any of the following conditions.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart Failure (weak heart)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure (hypertension)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart attack or angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol (hypercholesterolemia)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis or emphysema (COPD)	<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"/>
Allergies, runny nose, hay fever (allergic rhinitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood sugar (diabetes)	<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"/>
Peptic, stomach or duodenal ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastric reflux, heartburn or esophagitis (GERD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High pressure in the eyes (glaucoma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor circulation in the legs (peripheral vascular disease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble with blood not clotting properly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Print other medical conditions not listed above in the space provided. Example - <i>Glaucoma</i> →					

For more information about Medco, please visit us online at www.medco.com.

Please complete both pages and staple together.

Please return the questionnaire with your prescription or refill order form.

Thank you very much.