Magellan Rx Home

Mail Service Order Form

1 Member and physician information — please use black or blue ink. One form per member.

Member ID Number | Gender ☐ M ☐ F

Last Name | First Name | MI

Delivery Address | Apt. #

City | State | ZIP

Phone Number (list in order of preference) (circle one)
(_____)_____ M H W
(_____)_____ M H W
( ) M H W

Date of Birth / /

Email

Physician Name

Physician Phone Number ( )

2 Health history

Medication Allergies:

☐ Amoxil/Ampicillin ☐ Erythromycin ☐ None Known
☐ Aspirin ☐ NSAIDs ☐ Sulfa
☐ Cephalosporins ☐ Penicillin ☐ Tetracyclines
☐ Codeine ☐ Quinolones ☐ Others: _____

Health Conditions:

☐ Arthritis ☐ Glaucoma ☐ None Known
☐ Asthma ☐ Heart Condition ☐ Osteoporosis
☐ Cancer ☐ High Blood Pressure ☐ Thyroid Disease
☐ Diabetes ☐ High Cholesterol ☐ Others: _____

List all prescription, over-the-counter and herbal medications taken regularly: (use additional sheet if necessary)

3 Refills. To order mail service refills, enter your prescription number(s) here.

1: _____ 2: _____ 3: _____ 4: _____
5: _____ 6: _____ 7: _____ 8: _____

4 Pharmacy processing

Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost.

Keep on file. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to Pharmacy:

5 Payment and shipping information — do not send cash.

Standard delivery is included at no charge. Most prescription orders arrive within 7 days from the date your order is received. We will contact you if there is an extended delay in delivering your medications. Please call 800.424.1771 if you have any questions. Once shipped, medications may not be returned for a refund or adjustment. I authorize Magellan Rx to charge the following amount to my credit/debit card without prior notification: ____up to $150 ____up to $250 ____up to $_____ (Other Amount Greater than $250)

☐ **Ship overnight.** Additional charges will apply. Please call to verify pricing.
☐ **Charge to my NEW credit card.**
☐ **Charge to my credit card on file.**
☐ **Check enclosed.** All checks must be signed and made payable to: Magellan Rx Management

Credit Card Number

Visa, MasterCard, AMEX and Discover are accepted.

☐ **Keep this card on file.**

Expiration Date (Month/Year) /

Signature: **Date:**

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance, and other such expenses related to prescription orders. By supplying my credit card number, **I authorize Magellan Rx Management to maintain my credit card on file as payment method for any future charges.** To modify payment selection, Customer Service can be contacted at any time.

6 Mail this completed order form with your new prescription(s) to Magellan Rx Pharmacy (f/k/a ICORE Healthcare), PO Box 620968, Orlando, FL 32862. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

Magellan Rx MANAGEMENT℠