Mail Order Prescription Filling Instructions

US-Rx Care's Mail Order Prescriptions for Non-Specialty Medications are delivered through Prescription Mart, your contracted Mail Order Pharmacy.

Information For Prescribers

Your doctor can E-prescribe directly to: Prescription Mart (NPI: 1821120981)

Your doctor can also fax prescriptions to: 409-866-1317

Note: The pharmacy can only accept faxed prescriptions received directly from your prescriber's office.

Pharmacy Contact Information

Phone: 800-630-3206

Pharmacy Hours

Monday to Friday	7 am – 6 pm CST
Saturday	8 am – 1 pm CST
Sunday	Closed

Pharmacy Mailing Address	Prescription Mart PO Box 12607 Beaumont, TX 77726

You must register prior to obtaining your medications. There are two ways to register:

1) Online: For fastest registration simply register on-line at www.presmartinc.com
2) By mail: To ensure the pharmacy has all the needed information prior to dispensing medication for you, please complete the attached form and mail it along with your prescriptions to Prescription Mart at the provided mailing address.

Prescription Mart will contact you by phone before mailing your medication. Also, they will verify that the correct medication is being dispensed, confirm your credit card information for billing purposes, and verify your shipping instructions.

If you have general questions about your pharmacy benefit, please contact US-Rx Care Member Services at (877) 200-5533.

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PRESCRIPTIONMART

Patient Profile and Medication Order Form

If you are a new patient using this form to enroll with the mail order pharmacy and are not requesting prescriptions to be filled at this time, complete only Sections 1, 2, and 6. Complete a separate form for each patient.

For faster service, you can complete this form and request prescription refills online at: www.presmartinc.com.
For questions or assistance with this form, you may contact our customer service department at: 1-800-630-3206.

Mail completed forms to: PRESCRIPTION MART
P.O. BOX 12607 BEAUMONT,
TX 77726-2607

NEW PRESCRIPTIONS – Mail your new prescriptions with this form. Number of NEW prescriptions enclosed____

REFILLS – Indicate the prescriptions to be refilled in Section 3. Number of REFILL prescriptions requested _____

1 INSURANCE INFORMATION

Identification Number:	Group #:	RxBIN #:
Cardholder's Employer:		
If your prescriptions will be filed under workers' compensation, please provide your injury date: ___/___/___ (MM / DD / YYYY)		

2 PATIENT INFORMATION

◯ Check for Spanish

Patient Name: (First / Middle Initial / Last / Suffix (JR, SR))

Date of Birth: ___/___/___ (Month / Day / Year)	◯ Male ◯ Female	◯ Check here for Easy Open caps
Home Address: (Street Address / Apt./Suite #)		
City:	State:	Zip Code:
Daytime Phone #: ( ) -	Alternate Phone #: ( ) -	
Cell Phone #: ( ) -	◯ Check to receive text notifications & alerts	
Email address:	◯ Check to receive email notifications & alerts	
Doctor's Name:	Doctor's Phone #: ( ) -	

Please complete the following medical information if you are a new patient or information has changed:

Drug Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Latex ◯ NSAIDs
◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Medical Conditions: ◯ None ◯ Acid Reflux ◯ Anxiety ◯ Arthritis ◯ Asthma ◯ Depression
◯ Diabetes ◯ Heart Disease ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraines ◯ Osteoporosis
◯ Prostate ◯ Thyroid ◯ Other: _____

List other medications you take not filled by Prescription Mart (including over the counter supplements):

Prescription Mart may substitute FDA-approved generic medications for brand name medications unless you or your prescriber specify otherwise. If you DO NOT want generic medications, you must provide specific instructions (including drug names) below. Refusal of generics may impact your copay.

3 PRESCRIPTION REFILL INFORMATION:	
To request prescription Refills, write the Rx Number and medication name below.	
1.	2.
3.	4.
5.	6.
7.	8.

4 PAYMENT INFORMATION: AMOUNT AUTHORIZED: $_____

If your copay is $0, you do not need to provide payment information.

- ◯ Call me for payment information
- ◯ Check or money order enclosed (Payable to: Prescription Mart). Write your Member ID # on your check.
  Prescription Mart may charge up to $25 for returned checks.
- ◯ Charge credit card on file
- ◯ Apply credit balance to this order
- ◯ Please charge the following card:
  - ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express
  - Credit card number: | | | | | | | | | | | | | | | | |
  - Expiration Date: Billing Zip Code:
  - Name as it appears on card:
- ◯ Keep this payment method on file for future orders ◯ Use this payment method one time only

DO NOT SEND CASH.

CREDIT CARD HOLDER SIGNATURE:_____ DATE:_____

5 SHIPPING ADDRESS (if different from Home Address listed in Section 2):

First Name | Middle Initial | Last Name

Company Name (if applicable)

Street Address

City | State | Zip Code

- ◯ Check here if you would like us to use this shipping address for this order only and not future orders.
- ◯ Check here if you would like us to contact you to schedule expedited shipping at your expense.

If your medication(s) require special handling, a team member will reach out to you to advise when delivery is expected.

6 CERTIFICATION

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, sponsor, policy holder and employer in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

PATIENT SIGNATURE: _____ DATE:_____