OPTUMRx™

UnitedHealthcare®

New Prescription Mail-In Order Form

1 Please use black or blue ink and mail this completed order form with your new prescription(s). DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

Primary Member ID Number:		(Additional coverage, if applicable) Secondary Member ID Number:	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Email	
Physician Name		Physician Phone Number with Area Code	

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: _____

Over-the-counter/Herbal medications taken regularly:

3 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.
If you require brand-name medications, please list those medications here:

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:

4 Payment and shipping information — do not send cash.

Standard delivery is included at no charge. Most prescription orders arrive about 7 days from the date your completed order is received. If clarification of your order is required, delivery may take longer. If you would like overnight shipping, please indicate below. Please note that expedited shipping only affects shipping time, not the processing time of your order.

You may log on to **www.myuhc.com** to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

☐ **Ship overnight.** Add $12.50 to order amount (subject to change).
☐ **Check enclosed.** All checks must be signed and made payable to: OptumRx.
☐ **Charge to my credit card on file.**
☐ **Charge to my NEW credit card.**

New Credit Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date (Month/Year) ☐☐ / ☐☐☐☐

Visa, MasterCard, AMEX and Discover are accepted.

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 OptumRx 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.

OptumRx, P.O. Box 2975, Mission, KS 66201