MAILORDER PRESCRIPTION ENROLLMENT/CHANGE FORM

Please request mailorder prescriptions **10-14 days** before you need the medication. This allows time to contact your MD or insurance provider if needed. During the holidays, mail volume is often increased. Please be aware that mail is not delivered on post office holidays. Al controlled substances are mailed certified mail and will require a signature upon receipt.

CHECK BOX THAT APPLIES **NEW ENROLLMENT** ☐ **CHANGE** ☐

Please Check if Changing

EMPLOYEE INFORMATION (MUST BE FILLED OUT WITH ALL CHANGES)

Name	Birth Date	Employee # on Insurance Card (Begins with "A")

Drug Allergies

Circle One: Safety caps Easy-open caps

If secondary coverage exists, please provide a copy of the card (front and back)

Mailing Address

City | State | ZIP Code

Home phone ( ) | Work phone ( ) | Cell phone ( )

List **family members** on Mission Health Plan that will receive mail order and **include date of birth (DOB) for each person and allergies**

1. (___/___/___) Allergies
2. (___/___/___) Allergies
3. (___/___/___) Allergies
4. (___/___/___) Allergies

PLEASE PROVIDE EMAIL ADDRESS FOR DELIVERY CONFIRMATIONS AND TRACKING INFORMATION:

PAYMENT METHOD REQUIRED (PLEASE CHOOSE ONE PAYMENT METHOD TO REMAIN ON FILE)

❑ **Payroll Deduction**

Employee Name_____

7 Digit Employee ID #_____

Dept_____

Important information about Payroll Deduction:
*I hereby authorize the Payroll Department to deduct from my pay for prescriptions filled at my request by Mission's Mailorder Pharmacy for up to a 90-day supply of medication. My signature below acknowledges that this is a non-refundable payroll deduction. In the event of resignation/termination of my employment, any balance still remaining from this payroll deduction will be subtracted from my final paycheck. **The maximum # of deductions will be used for all payroll deductions – see chart at right.*

Employee Signature:_____ **Date**_____

If total is**	Will be deducted from this # pay periods
Up to $30	1
$31-50	2
$51-75	3
$76-100	4
$101 and up	5

❑ Circle one: **Debit** **Credit Card**

Cardholder Name | Type: ❑Visa ❑Mastercard ❑Discover

Card #:___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

*Expiration Date (MM/YYYY)*_____ | CVV code (3 or 4-digits on back):___ ___ ___ ___

Cardholder Signature:_____Date_____

I authorized Mission Pharmacy-Employee Mailorder to bill my credit/debit card for this and all future orders. I understand that my credit/debit card will be billed at the time my order is filled.

AUTHORIZATION

By signing below, I certify that the information on this form is correct, and I authorize the release of information regarding my medical and prescription drug history to Mission Mail Order Pharmacy.

Employee Signature *Date*

Email, Mail, or Fax Completed Form along with copies of other prescription insurance information to
Mission Pharmacy – Employee Mailorder – 400 Ridgefield Court, Suite 106, Asheville, NC 28806
Phone (828) 257-7057 // Fax (828) 257-7059 // MailOrder.Pharmacy@msj.org
We regretfully cannot accept faxed or photocopied prescriptions from patients.

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