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. All controlled substances are mailed certified mail and will require a signature upon receipt.

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

PRIMARY CARD HOLDER INFORMATION (MUST BE FILLED OUT WITH ALL CHANGES)

Name:_____ **Birth Date:** _____

Drug Allergies:_____ **Insurance Number:** _____

Mailing Address: _____

City:_____ **State:** _____ **ZIP Code:**_____

PHONE: Home( )_____**Cell( )**_____**Work( )**_____

Safety Caps: Yes or NO (*Please Circle One*)

Email address for delivery confirmations and tracking information:_____

I give Mail Order Pharmacy authorization to place my prescriptions for myself and my dependents on automatic refill. I will be responsible for contacting Mail Order if there are any discontinuations in medications before they are processed. I also understand that if I decline for automatic refill, that it will be my responsibility to contact Mail Order for any refill requests, including new prescriptions.◯YES◯NO (*please circle one*)

List any dependent family members, date of birth (DOB), and allergies for each person ON Insurance

1. _____ (__/__/____) Allergies _____
2. _____ (__/__/____) Allergies _____
3. _____ (__/__/____) Allergies _____
4. _____ (__/__/____) Allergies _____
5. _____ (__/__/____) Allergies _____
6. _____ (__/__/____) Allergies _____

Credit Card Payment ❑ Visa ❑ Mastercard ❑ Discover

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

Cardholder Name _____

Card #:___ ___ ___ ___ - ___ ___ ___ ___ -___ ___ ___ ___ -___ ___ ___ ___ CVV code: ___ _____

*Expiration Date (MM/YYYY)*_____

Cardholder Signature:_____ **Date**_____

I authorized Mission Pharmacy-Employee Mailorder to bill my credit/debit card for this and all future orders 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.

Patient 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// NCDV.MailOrderPharmacy@hcahealthcare.com

We regretfully cannot accept faxed or photocopied prescriptions from patients.

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