

For Internal Use Only

New Rxs # Refills Operator's Initials

Check or Money Order #
Amount
CTC # of Coupons



BlueCross BlueShield of Texas

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company*
HMO plans offered by and HealthSelect Plus administered by Southwest Texas HMO, Inc. *d/b/a HMO Blue Texas
*Independent Licensees of the Blue Cross and Blue Shield Association

Please mail this form to:
AdvanceRx.com
P.O. Box 961066
Fort Worth, TX 76161-0066

For rapid refills, call 1-877-299-2377 (HMO members only) or 1-800-521-2227 (all other members) or visit www.AdvanceRx.com

Mail Order From 8705.972-901

Cardholder Information - Please print within the boxes using black ink.

Cardholder ID # (generally your SSN) Group # (on your member ID card [if applicable])

Last Name of Cardholder First Name of Cardholder MI

Delivery Address (If you select 2nd Day or Next Day shipping, fill in a street address, not a P.O. Box.)

City State Zip

Above delivery address is for: (check only if applicable) this order only permanent address change

Daytime Phone Evening Phone

E-mail Address (if available) Providing your e-mail address authorizes us to e-mail you information about your AdvanceRx.com account.

Doctor's Name Doctor's Phone

Doctor's Name Doctor's Phone

Payment Options - Payment to AdvanceRx.com is due with each order. Do not send cash. Refer to your benefit materials for copayment amount(s).

Check # Money Order #

Check or money order amount \$

Please write your cardholder ID number on your check or money order. There is a \$10.00 returned check charge.

MasterCard VISA American Express Discover

Account # Exp. Date MM YYYY

If you use a credit card for your payment, AdvanceRx.com will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Cardholder's Signature

Delivery Options

Please allow 14 days from the date you mail your order for delivery of your medicine.

Choosing 2nd Day or Next Day delivery affects only shipping time, not the processing time of your order.

- Standard Postal (no charge)
2nd Day (\$10.00)
Next Day (\$13.00) (Weekend deliveries not available)

Special Instructions

Prescription Bottle Cap: A child-resistant cap is included with every order. Please check the following box if you would also like an easy-open cap.

¿Quiere las instrucciones en español? (Spanish label instructions?) Sí/Yes

If you do not want your doctor or prescriber contacted about a clinically appropriate, potentially cost-saving preferred drug, check here:

Health History (Please ✓check all that apply to you, your spouse or covered dependent[s].)

Simply complete information for all covered family members. If you are unsure about any health conditions, check with your doctor. This portion will not be required on subsequent orders unless there have been changes in health or coverage status.

	Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	M / F	No Known Allergy 010000	Penicillin Allergy 031000	Sulfa Allergy 040000	Other Allergy 000000	Diabetes 050000	Thyroid 060000	Heart Condition 10000	High Blood Pressure 120000	Ulcers 18100	Epilepsy 292019	Glaucoma 301000	Other Conditions
Member															
Spouse															
Dependent															
Dependent															
Dependent															
Dependent															

If you have additional dependents or require more space, please attach a separate note.

New Prescriptions – Please enclose your original, written prescription and payment with this form. Ask your doctor to write a mail order prescription to maximize the supply as allowed by your plan.

Refill Prescriptions – For rapid refills, visit the Web site or call the toll-free number on your prescription label.

Affix refill label in space below or fill in prescription information. For additional refills, use the Comments section or attach a separate sheet of paper.

If you misplace the envelope for your new prescription order, please call the toll-free number on the front of this form. For refill prescriptions, mail your order to the address on your prescription label.

Patient's Name _____
Rx # _____ Drug Name _____
Doctor's Name _____
Doctor's Phone # _____

Patient's Name _____
Rx # _____ Drug Name _____
Doctor's Name _____
Doctor's Phone # _____

Comments (Please print clearly)

By returning this form to AdvanceRx.com, you authorize the use and release of information to your plan sponsor, plan administrator, health care providers and their agents for use in connection with the management of your health benefits and those of your covered dependents.

AdvanceRx.com will substitute an available generic equivalent for certain brand-name drugs whenever allowed by your doctor and applicable pharmacy law. If you do not want a generic substitution for a specific medication, please note in the Comments section.