866.744.0621 | MedVantxRx.com

Pharmacy Services

MEMBER INFORMATION

Cardholder ID# (Refer to ID Card)

Group # (Refer to ID Card if applicable)

Last Name of Cardholder

First Name of Cardholder

Delivery Address (Street and Apartment Number)

City

State

Zip Code –

Email Address

Daytime Phone Number – –

Date of Birth (MM/DD/YYYY) – –

Gender ☐ M ☐ F

Drug Allergies:

- ☐ No Known Allergy
- ☐ Codeine
- ☐ Penicillin
- ☐ Iodine
- ☐ Sulfa
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Other ______

Health Conditions:

- ☐ Arthritis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Depression
- ☐ Asthma
- ☐ Glaucoma
- ☐ High Cholesterol
- ☐ Thyroid
- ☐ Ulcer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Other ______

List any OTC, herbal, or other medications you take regularly: ______

PAYMENT OPTIONS

Payment to is due with each order. **Do not send cash**. If you use a credit card for your payment, MedVantx will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Credit Card Type (Our preferred payment method for faster service)

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Account Number

Expiration Date /

Security Code

☐ Check or money order enclosed. Cardholder Signature: ______ Date: ______

REFILL OPTIONS FOR FASTER SERVICE, PLEASE VERIFY AVAILABLE REFILLS AND CALL US TOLL FREE AT 866.744.0621.

Additional forms can be obtained by contacting customer service or by visiting our website.

Patient: ______

Rx# Rx# Rx#

Notes to Pharmacy:

PLEASE READ AND SIGN TO COMPLETE ORDER

I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment and prescription drug history to MedVantx Pharmacy Services.

Signature: ______ Date: ______