

Prescription Mail Order Service

We have partnered with Agelity, Inc. to provide members with the very best in prescription mail order services.

Our mail order service:

- Provides Additional Prescription Savings
- Has No Shipping and Handling Fees¹
- Has No Monthly Fees
- Saves You Time
- Is Convenient
- Confidential
- Simple To Use

Why should I use this service?

Our Mail Order Service purchases its drugs in large quantities and is able to pass its volume buying savings on to you.

When should I use this service?

Our Mail Order Service is most beneficial for (but not limited to) individuals using maintenance type medications for 30 days or longer to treat chronic or long-term conditions. Some of these conditions include diabetes, arthritis, heart conditions and high blood pressure.

What other services do you provide?

We provide Over the Counter and Durable Medical, as well as incontinence and Wound Care, Vitamins, and Diabetic Supplies

Are there any eligibility restrictions associated with this service?

No, your current membership entitles you and your family members to participate.

Are there any fees associated with this service?

No, your current membership covers you and your family members at no additional cost¹. In fact, we even cover the shipping unless Priority, Express or cooler service is required.

¹Over the Counter and Durable Medical orders must be \$15.00 or more to be shipped for free.

How else can I save money?

Use generic drugs when possible

How do I order a prescription for the first time?

For each member filling a prescription:

1. Provide prescription(s) from your doctor.
2. Complete the enrollment form provided below.
3. Return the enrollment form, along with the prescription(s), to the address indicated on the application.

How do I refill my prescription?

1. You can call in your refill orders 24 hours a day, 7 days a week at: 800-854-8764

OR

2. Complete the enrollment form provided below and include the prescription numbers

OR

3. Go to www.drugsourceinc.com

Can I transfer a prescription from my existing pharmacy?

Yes, simply fill in the additional transfer information on the enrollment form provided.

Can I fax my prescription to the mail order service?

New prescriptions can only be faxed by a physician, but you may fax in a refill order or transfer form.

Fax Number: 847-258-1913

Drugsource, Inc. New Patient Profile Form
Patient Profile Registration – Complete the form below.

Email Address

Group Number

Check here if new address

Member's Name

Middle

Last Name

Address

Apt.

Phone

Daytime Phone

City

State

Zip Code

Member's Date of Birth

Male

Female

Are you pregnant at this time?

Yes

No

Describe Member's drug allergies and medical conditions

Check here if none:

Name of Physician ordering medication

Physician Phone Number

Member's ID Number

Member's Dependent Information

Patient's Name

Sex

Relationship

Doctor's Name/Phone

Date of Birth

List of any allergies or Medical Conditions

Member's Dependant Information

Patient's Name

Sex

Relationship

Doctor's Name/Phone

Date of Birth

List of any allergies or Medical Conditions

Refills

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Member's Credit Card Information

Please charge my credit card VISA MASTERCARD DISCOVER AMER. EXPRESS

Credit Card Number _____

Exp Date _____

Generic Medication Information

Yes, I authorize DrugSource to dispense generic medications.

No, I do not authorize DrugSource to dispense generic medications.

I certify the information on this form is correct, and authorize release of all information to Plan Administrator.

Signature : _____ Date: _____

Would you like a call from the Pharmacist to discuss any medical questions that you may have? Yes No

I certify the information on this form is correct. I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, and sponsor in accordance with the Health Insurance Portability and Accessibility Act (H.I.P.A.A).

Please see the "Patient Prescription Form" on the following page.

**Send all forms to: DrugSource, Inc.
P.O. BOX 1366
Elk Grove Village, Illinois 60009-1366
To contact us toll free call: 1(800) 854-8764**

Drugsource, Inc. New Patient Prescription Form
Patient Prescription Information – Complete the form below.

TRANSFER PRESCRIPTION FORM

To transfer an existing prescription from another pharmacy, please fill out the above information as well as the table below.

Patient Name	Rx #	Drug Name	Drug Quantity	Prescription Directions	Pharmacy Name	Pharmacy Phone #

Please fill out the following section if you want us to contact your physician.

Medication Name	Medication Info	Prescription Directions	Doctor Information	Fill	Patient
	Strength: ____ Quantity: ____		Name: _____ Phone: _____ Fax: _____	<input type="checkbox"/> Now <input type="checkbox"/> Later	
	Strength: ____ Quantity: ____		Name: _____ Phone: _____ Fax: _____	<input type="checkbox"/> Now <input type="checkbox"/> Later	
	Strength: ____ Quantity: ____		Name: _____ Phone: _____ Fax: _____	<input type="checkbox"/> Now <input type="checkbox"/> Later	
	Strength: ____ Quantity: ____		Name: _____ Phone: _____ Fax: _____	<input type="checkbox"/> Now <input type="checkbox"/> Later	

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