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	Mail this form to:
Member ID # (if not shown or if different from above)	Ilini IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII
Prescription Plan Sponsor or Company Name	
Instructions: Please use blue or black ink and print in capital let	ters. Fill in hoth sides of this form
New Prescriptions - Mail your new prescriptions with	
Refills - Order by web, phone, or write in Rx number(s TO RECEIVE YOUR ORDER SOONER request refill website/phone number on your member ID card.) below. Number of Refill prescriptions:
A Shipping Address. To ship to an address different	from the one printed above, enter the changes here.
Last Name	First Name MI Suffix (JR, SR)
Street Address	Apt./Suite # Use shipping address for this order only.
City Daytime Phone #:	State ZIP Code Evening Phone #:
B Refills. To order mail service refills, enter your pres	scription number(s) here.
1)2)	3)4)
5)6)	7)8)
getting a new prescription, be sure to ask your docto plan, usually a 90-day supply. Make sure your doctor to provide you with high quality medicines at the besi equivalent generic medicines for brand name medici	t possible price. In order to do this, we will substitute

Services provided by CarelonRx Inc.

We may package all of these prescriptions together unless you tell us not to.



First person with a refill or new prescription.	○ Spanish forms and labe
Last Name First Name	Suffix (JR,SR)
Nickname Date of bir	th:
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Doctor's last name Doctor's first name	Doctor's phone #
Tell us about new health information for 1st person if never p Allergies: None Aspirin Cephalosporin Codein Sulfa Other:	
Medical conditions: () Arthritis () Asthma () Diabetes () Aci () High blood pressure () High cholesterol () Migraine () () Other:	Osteoporosis O Prostate issues O Thyroid
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Tell us about new health information for 2nd person if never Allergies: None Aspirin Cephalosporin Codein Sulfa Other:	e () Erythromycin () Peanuts () Penicilli
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