Prescription Mail Service Order Form

Prescription plan sponsor or company name: Cleveland State University

Mail order form to: Plaza Pharmacy
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland OH 44109-1998

If you have any question, please call 216-778-7548 or 1-877-509-0598.

MetroHealth will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

Directions

- Print in **blue** or **black** ink, using **capital** letters. Fill in circles completely. Complete both sides of the form.
- To order new prescriptions:
  Mail your prescription(s) with this form. # of new prescriptions: _____
- To order refills:
  Write in Rx number(s) below. # of refill prescriptions: _____

Member Information

Member ID (SS# or ID#): _____ Group #: CSURX

Last name: _____

First Name: _____ MI: _____ Suffix (Jr., Sr.): _____

Street address: _____ Apt./Suite#: _____

City: _____ State: _____ Zip code: _____

Daytime phone #: _____

Evening phone #: _____

(Mark with an 'X') __ **Use this address for this order only.**

Refill Information

To order mail service refills, enter your prescription number(s) here:

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Important notice: When getting a new prescription, be sure to ask your doctor to write your prescription for the maximum amount allowed by your benefit plan, usually a 90-day supply. Make sure your doctor **signs** and **dates** all new prescriptions.

Prescriptions sent in one envelope may be shipped together unless you request otherwise.

Fill in up to two people who will receive prescriptions with this order.

1st person ordering a prescription

Last name: _____ First Name: _____ MI: _____

Gender: ○ Male ○ Female Date of birth (mm-dd-yyyy): _____

Select one: ○ Cardholder ○ Spouse ○ Dependant Your e-mail: _____

Doctor's last name: _____

Doctor's first name: _____ Doctor's Phone #: _____

Allergy/Health Information: complete only if changed or not previously reported. (Mark with an 'X')

Allergies: __ None __ Aspirin __ Cephalosporin __ Codeine __ Erythromycin
__ Sulfa __ Peanuts __ Penicillin __ Other: _____

Conditions: __ Arthritis __ Asthma __ Diabetes __ Acid reflux
__ Glaucoma __ Heart problem __ High blood pressure __ High cholesterol
__ Migraine __ Osteoporosis __ Prostate issues __ Thyroid
__ Other: _____

Special instructions: _____

Fill in up to two people who will receive prescriptions with this order.

2nd person ordering a prescription

Last name: _____ First Name: _____ MI: _____

Gender: ○ Male ○ Female Date of birth (mm-dd-yyyy): _____

Select one: ○ Cardholder ○ Spouse ○ Dependant Your e-mail: _____

Doctor's last name: _____

Doctor's first name: _____ Doctor's Phone #: _____

Allergy/Health Information: complete only if changed or not previously reported. (Mark with an 'X')

Allergies: __ None __ Aspirin __ Cephalosporin __ Codeine __ Erythromycin
__ Sulfa __ Peanuts __ Penicillin __ Other: _____

Conditions: __ Arthritis __ Asthma __ Diabetes __ Acid reflux
__ Glaucoma __ Heart problem __ High blood pressure __ High cholesterol
__ Migraine __ Osteoporosis __ Prostate issues __ Thyroid
__ Other: _____

Special instructions: _____

Payment Information: Select one payment method below.

Credit Card: ○ VISA® ○ Mastercard® ○ Discover®

(Mark with an 'X') __ I authorize MetroHealth to charge this card for all orders from any person in this membership.

Card #: _____ Exp. Date (mm/yy): _____

Card holder signature _____ Date: _____