

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

 M F

Patient's relationship to member

 Self Spouse Dependent

Doctor's last name

1st initial

Doctor's phone number

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire. **There may be a limit to the balance** that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

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

Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

Check the box if you do not wish a less expensive brand or generic drug.

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at Express-Scripts.com/TRICARE or call Member Services at 1.877.363.1303. TTY/TDD users should call 1.877.540.6261.

Federal law prohibits the return of dispensed controlled substances.

Program: <<XXXXXXXXXX>>



Place your prescription(s), this form, and your payment in the envelope provided. Be sure the address shows through the window. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 52150
PHOENIX, AZ 85072-2150



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Privacy Act Statement from the Department of Defense

To activate your account, please complete the fields below. Before doing so, you must read this Privacy Statement from the Department of Defense.

Authority: 5 U.S.C. 301 (Departmental Regulations); 10 U.S.C. §§1095b-1095c, and §1097 (Medical and Dental Care); 45 C.F.R. Part 160 and Subparts A and E of Part 164 (Health Insurance Portability and Accountability Act); DTMA 04 (Medical/Dental Claim History Files); and, E.O. 9397, as amended (SSN).

Purpose: Information is being collected to provide pharmacy services to all TRICARE beneficiaries

Routine Uses: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, this information may specifically be used to verify beneficiary eligibility, to provide contracted pharmacy benefits services, to authenticate and identify DoD affiliated personnel, and to register new DoD civilian and military personnel and their authorized dependents for the purpose of obtaining medical benefits or other benefits for which they are qualified.

Disclosure: Submission of this information is voluntary. However, failure to provide the requested information may result in delayed processing of pharmacy services.