

Last Name of Cardholder First Name of Cardhold	MEMBER INFORMATION				Pharmacy Services
Last Name of Cardholder Delivery Address (Street and Apartment Number)	Cardholder ID# (Refer to ID Card)				
Delivery Address (Street and Apartment Number) City State Zip Code Email Address Daytime Phone Number Date of Birth (MM/DDYYYY) Gender Daytime Phone Number Date of Birth (MM/DDYYYY) Gender Aspirin Port Port Port Port Aspirin Erythromycin Other Health Conditions: Arthritis Diabetes High Blood Pressure Heart Condition Depression Asthma Glaucoma High Cholesterol Thyroid Ulicer Diabetes Epilepsy Other List any OTC, herbat, 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 protion of the drug cost, any special delivery charges and any outstanding balance due. Credit Card Type (our prefered 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# RX# Notes to Pharmacy:	Group # (Refer to ID Card if applicable)				
State Zip Code	Last Name of Cardholder			First Name of Ca	rdholder
State Zip Code					
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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 protion 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# Rx# Notes to Pharmacy: PLEASE READ AND SIGN TO COMPLETE ORDER Certify that the information provided on this form is correct and authorize the release of information generating medical biscapt text text text to the certified of the provided on this form is correct and authorize the release of information generating medical biscapt text text text text to the certified of the provided on this form is correct and authorize the release of information generating medical biscapt text text text text text text text te	Daytime Phone Number		Date of Birth (MM		Gender
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Account Number Expiration Date 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# Notes to Pharmacy: PLEASE READ AND SIGN TO COMPLETE ORDER certify that the information provided on this form is correct and authorize the release of information regarding medical history treatment.	_	_		liscover	
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