



EZ Rx Pharmacy
Confidential Patient Profile and Prescription Order Form

Member Information

Plan Number (if any):

Member I.D. Number:

Name (Last) (First) (M.I.) Daytime Area Code and Phone Number

Form fields for name and daytime area code and phone number

Street Address City Evening Area Code and Phone Number

Form fields for street address, city, and evening area code and phone number

State: Zip Code Date of Birth Day Year

Form fields for state, zip code, date of birth, day, and year

Prescribing Physician Name

Physician Phone Number Fax Number

First Time Users: Use this form to register with EZ RX Pharmacy at the time you place your first order. The information below is for the member indicated above and will be used to check potential drug interactions when you have prescriptions filled through us.

- SEX: Male, Female
ALLERGIES: None, Aspirin, Codeine, Erythromycin, Penicillin, Sulfa, Other - Specify Below
HEALTH CONDITIONS: Asthma, Diabetes, Glaucoma, Heart Condition, High Blood Pressure, Seizure Disorder, Thyroid, Arthritis, GERD (Acid Reflux), High Cholesterol, Migraines, Osteoporosis, Ulcers, Other - Specify Below

Please list other allergies or health conditions:

Payment Information

Number of Rx's Enclosed

Please Make Check Payable To: EZ Rx Pharmacy, 6916 W. Linebaugh Ave. Suite 101, Tampa, Fl. 33625

Payment Method

Form for payment method selection: Visa/Master Card, American Express, Discover, Money Order, Check, Do Not Send Cash

Credit Card Number: Expiration Date:

Form fields for credit card number and expiration date

Unless the box below is checked, your credit card will be kept on file and you are authorizing its use for future orders

I do not want my credit card used for future orders Signature:

WHAT ARE MAINTENANCE DRUGS

Maintenance drugs are used to treat long lasting or chronic conditions and are taken for an extended period of time. They include medications for high blood pressure, arthritis, heart conditions, birth control, cholesterol, asthma and others. EZ Rx is a convenient dependable and less expensive way to obtain your maintenance medications.

WHAT ARE GENERIC DRUGS

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. Generic drugs meet the same FDA standards and have the same active ingredients, strength and effect as brand name drugs.

EZ Rx buys only the highest quality generic medications available. Unless your physician has specified otherwise, (i.e. hand written " Medically necessary") your prescription will be filled with a generic equivalent when available and permissible.

HOW DO I USE EZ RX FREE HOME DELIVERY SERVICE

1. Let your physician know you have EZ RX PHARMACY FREE HOME DELIVERY SERVICE
2. Complete the Confidential Patient Profile attached to this form.
3. Use the self-addressed postage paid envelope to enclose the following:
 - a. Your Confidential Patient Profile
 - b. The original prescription with refills
 - c. Payment for your portion of the prescription, based upon your health plan (co-payment)

You will receive your medication within one week via Courier, US Mail Service, or UPS right to your doorstep once a month at no cost to you. Emergency orders can be sent overnight for an additional fee if necessary.

HOW DO I GET A REFILL

- During business hours you may call your EZ Rx Customer Service Representative at 813- 960-2020 or 1-877-436-2020.
- Complete your reorder form and return it in the EZ Rx self-addressed envelope.

All questions regarding the EZ Rx free home delivery service program should be directed to:



1-877-436-2020

6916 W. Linebaugh Ave. Suite 101

Tampa, Fl. 33625

813- 960-2020

8:30AM to 5:30PM

Monday – Friday

Or have your physician call or fax to EZ Rx your new prescription(s):

Authorization PLEASE READ AND SIGN: I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor and I AUTHORIZE EZ Rx TO SUBSTITUTE FDA APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PHYSICIAN'S ORDERS AND MY BENEFIT PLAN.

Signature: _____ Date: _____