Health Direct Pharmacy Services

about us... Health Direct Pharmacy Services, is located at 1226 US Hwy Route 11 in Gouverneur, New York 13642. Health Direct is committed to providing its customers with superior customer service and convenient access to our products and services. You can contact Health Direct Pharmacy Services, toll-free at 1-888-425-3301

Order Form

Detach and return along with your prescription(s) and any necessary co-payment in the postage paid envelope.

INSURED FAMILY MEMBER'S NAME_____

PLAN NAME_____ MEMBER ID NO._____

SHIP TO:

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PLEASE CHECK THE APPROPRIATE DESIGNATION: ☐ PERMANENT ADDRESS ☐ SEASONAL ADDRESS ☐ TEMPORARY ADDRESS

HOME PHONE_____ WORK PHONE_____

COMMENT/REFILL REQUESTS

Provide prescription numbers for refill and/or any other information to help ensure the accurate and timely processing of your order.

_____

_____

_____

_____

PRESCRIPTIONS ENCLOSED FOR:

NAME_____ DATE OF BIRTH_____

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT SEX: ☐M ☐F

NUMBER OF PRESCRIPTIONS ENCLOSED (INCLUDE BOTH NEW AND REFILL)_____ TOTAL CO-PAY (THIS INDIVIDUAL)_____

PRESCRIPTIONS ENCLOSED FOR:

NAME_____ DATE OF BIRTH_____

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT SEX: ☐M ☐F

NUMBER OF PRESCRIPTIONS ENCLOSED (INCLUDE BOTH NEW AND REFILL)_____ TOTAL CO-PAY (THIS INDIVIDUAL)_____

Getting Started

To receive medications from Health Direct Pharmacy Services you must first establish a patient profile. To do that you may:

a) Enclose a completed **patient profile form** in the postage paid envelope the first time you order a medication.

~ or ~

b) Call our customer service representative toll free at **1-888-425-3301** to establish your profile ahead of time.

Once your profile has been established, it is no longer necessary to complete a **patient profile form to** order medications, unless you need to inform Health Direct Pharmacy Services of any changes in your medical history.

Notice of Privacy Practice

You will be sent Health Direct Pharmacy Services Notice of Privacy Practices the first time you receive an order. Federal law mandates that the pharmacy retain your signature acknowledging the receipt of that notice. After you receive the notice, please sign the acknowledgment and return it with your next order.

Ordering New Medications

When you receive a new written prescription from your doctor for up to a 90 day supply of medication, simply:

1.) Complete an **order form** making sure to indicate where you would like the prescription shipped and verify which of your family members it is for. Then...

2.) Send the **original prescription**, the completed **order form** and any necessary co-payment to Health Direct Pharmacy Services in the postage paid envelope.

Ordering Refills

Once you have placed your original order and need a refill, you can do any of the following:

a) Order your refill on-line at **www.healthdirectpharmacy.com/PBD**
(enroll in the Automatic Refill program for added convenience)

b) Order your refill toll free by phone at **1-888-425-3301** on the 24 hour automated refill system

c) Order your refill by mail with an **order form** in the postage paid envelope.

Profile Form

INSURED FAMILY MEMBER

LAST NAME_____ FIRST NAME_____ M.I._____

DATE OF BIRTH_____ SEX ☐M ☐F

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____

LIST KNOWN DRUG ALLERGIES_____

LIST KNOWN MEDICAL CONDITIONS_____

SPOUSE

LAST NAME_____ FIRST NAME_____ M.I._____

DATE OF BIRTH_____ SEX ☐M ☐F

LIST KNOWN DRUG ALLERGIES_____

LIST KNOWN MEDICAL CONDITIONS_____

DEPENDENT

LAST NAME_____ FIRST NAME_____ M.I._____

DATE OF BIRTH_____ SEX ☐M ☐F

LIST KNOWN DRUG ALLERGIES_____

LIST KNOWN MEDICAL CONDITIONS_____

DEPENDENT

LAST NAME_____ FIRST NAME_____ M.I._____

DATE OF BIRTH_____ SEX ☐M ☐F

LIST KNOWN DRUG ALLERGIES_____

LIST KNOWN MEDICAL CONDITIONS_____

RECEIPT OF PRIVACY PRACTICES

I acknowledge receipt of the Health Direct Pharmacy Services Notice of Privacy Practices.

_____ SIGNATURE OF INSURED FAMILY MEMBER

_____ PRINTED NAME OF INSURED FAMILY MEMBER

_____ DATE