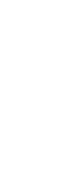
Standard delivery is at no charge. Most orders arrive about 7 days from the date your completed order is received. If clarification of your order is required, delivery may take longer. If you would like overnight shipping, please indicate below. Please note that expedited shipping only affects shipping time, not the processing time of your order.								
Ship overnight. Add \$12.50 to order amount (subject to change).								
Check enclosed. All checks must be signed and made payable to Prescription Solutions.								
Charge to my credit card on file.								
Charge to my NEW credit card.								
New Credit Card Number			Expiration Date (Month/Year)					
Signature:			Date:					
This credit card will be billed for applicable medications, ov credit card on file as payment method for any future charg	ernight shipping and outstand es or outstanding balances. To	ding balances. o modify paym	I authorize Prescription Solutions to maintain nent selection, please contact Customer Servic	my e.				
lere Dei Mail with the original prescripti 7985 000	tach and fold at the dotte ion(s) to Prescription Sol		the attached envelope.					
/ 505_000								

Fold Here



P.O. Box 2975, Shawnee Mission, KS 66201-1375 1.800.562.6223 www.PrescriptionSolutions.com



PRESCRIPTION SOLUTIONS PO BOX 2975 SHAWNEE MISSION KS 6620

6620

375



RETURN

ADDRESS

Frequently Asked Questions

1. Can mail service help me save money compared to a retail pharmacy?

Yes, most plans entitle members to a discounted copay when they order their medications through mail service.

2. Does Prescription Solutions have other ways to help me keep costs down?

Yes. One way is by recommending less expensive alternatives to brand-name medications whenever appropriate.

3. Can Prescription Solutions ship medications that need refrigeration?

Yes. We ship perishable medications overnight at no charge in a temperature-controlled package.

4. Is it safe to send medications through the mail?

Yes, all medications are sealed and shipped in a discreet, tamper-evident package, ensuring that your order arrives safely.

Questions?

Our Customer Service Advocates and licensed Pharmacists are available at 1.800.562.6223, 24 hours a day, 7 days a week, to assist you with any questions or concerns. You can also visit our website at www.PrescriptionSolutions.com.

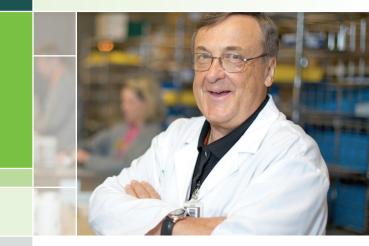
MSB-0084 UHEX3241498 000



PrescriptionSolutions[®]

A UnitedHealth Group Company

Enjoy the Many Benefits of Your Mail Service Pharmacy



Prescription Solutions can deliver 90-day supplies of your medications right to your mailbox, often for less than you would pay at a retail pharmacy.

Here's how our process works:



When your order arrives, it enters our automated system. A licensed pharmacist reviews your order for drug interactions, allergies and dosage.

After your medication is dispensed, 2 another pharmacist reviews it a final time to ensure accuracy.



Your medication is sealed in a discreet, tamper-evident package. We then mail it directly to you and let you know when it has been shipped.



New orders should arrive approximately 7 days after your completed order is received, unless we need additional information from your prescribing physician.



We'll notify you when it is time to refill your prescription. You can reorder by mail, phone or online at www.PrescriptionSolutions.com.

Start Home Delivery in Two Easy Steps

Step 1

Tell your physician you would like to start mail service.

Once you and your physician are confident you will continue taking a medication on an ongoing basis, your physician will write you a prescription for a 90-day supply, plus 3 refills.

Step 2

Contact Prescription Solutions.

You can mail the order form

Include the original prescription(s). Write the member ID and date of birth on each prescription and mail with the completed order form(s). Please fill out one order form per member.

Or you can call 1.800.562.6223 (TTY 711)

Prescription Solutions is available 24 hours a day, 7 days a week. Please have your medication name and physician's telephone number ready when you call.

New Prescription Mail-In Form

(Use black or blue ink and fil and date of birth on each ou DO NOT STAPLE OR TAPE F	riginal prescr	iption a	nd mail	with the co				
	Member ID:		Plan Name:						
	Last Name				ne	MI			
	Delivery Address			1			Apt. #		
old	City	State	ZIP		Phone Numb	per)			
lere	Date of Birth (mm/dd/yyyy) / /	Gender	Email						
(2 Health History – please check all that apply.								
	f you are a new customer or your allergies or health conditions have changed, please indicate all that apply. The information you provide will allow a more complete review of your current medication request.								
	Medication Allergies:	Sulfa Medications							
	None	hromycin			Tetracyclines	Tetracyclines			
	Amoxicillin/Ampicillin	NSA	IDs (e.g. Il	ouprofen)		Other (please	(please specify)		
	Aspirin	cillin							
	Cephalosporins (e.g. Cephalexin)								
	Health Conditions:	H	eart Cond	ition	Other (please	Other (please specify)			
	None Can	cer	🗌 Hi	igh Blood Pressure					
				igh Cholesterol					
	Arthritis Glaucoma Thyroid Disease								
old lere	Please list any over-the-counter or her			5					
		Sai medications	you take	regularly.					
							_		
(3) Generic Substitution								
FDA-approved generic equivalents will be dispensed for brand-name medications whenever possible, unless you or your physician indicate otherwise. If you require brand-name medications, please list those medications in the Notes to Pharm section below with a brand-name only notation. Note: brand-name medications may be subject to a higher cost. Notes to Pharmacy:									

PrescriptionSolutions°