

Internet Prescription Order Form

Customer Service

1 (800) 962-8192

TDD, 1 (800) 221-6915

Mon.-Fri., 9 a.m. – 11 p.m. Eastern time

Sat., 9 a.m. – 5 p.m. Eastern time

Mail to:

Anthem Prescription Management, LLC

P.O. Box 746000

Cincinnati, Ohio 45274-6000

Please allow 14 calendar days for delivery

Ship to:

Cardholder's name		Cardholder's ID number	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Other	
Street	Apt. number	E-mail address	Phone (day/evening)	
ATTACH ADDRESS LABEL HERE				
City		State	ZIP code	

Payment information

Payment must be included with order. Make check or money order payable to Anthem Rx. There is a \$25 fee for returned checks.			Exp. Date Mon. <input type="checkbox"/> <input type="checkbox"/> Yr. <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> AMEX Account number _____			
Total amount due* \$	Please sign for credit card order.	Do you want safety caps included in your order? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**If you miscalculate the "total amount due," your card will automatically be billed the correct amount. Please check your invoice when this prescription arrives for the actual amount billed to your card.*

New prescription orders

Name of patient for whom the prescription is enclosed	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Have you taken this medication before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>Anthem Rx Direct pharmacists will dispense federally approved, generic equivalent medications for brand-name medications</i>			
<input type="checkbox"/> <i>I do not want to receive a generic equivalent (please be aware if you check this box, you will be responsible for a higher copay)</i>			
Doctor(s) name and phone number(s)		Doctor(s) name and phone number(s)	
Drug allergies/health concerns (Feel free to enclose additional information on a separate sheet of paper.)			
Other medications being taken (including over-the-counter)			

REFILL orders

Refill numbers	Patient name	Medication names
Refill numbers	Patient name	Medication names

For your convenience, a 24-hour automated telephone order system is also available for placing refill orders and for checking order status.

TO REORDER PLACE REFILL LABEL
HERE

TO REORDER PLACE REFILL LABEL
HERE