

# Fax Order Form

**NOTE: ORDERS NOT FAXED FROM A LICENSED PHYSICIAN'S OFFICE WILL NOT BE PROCESSED.**

**Physician:** Fax completed form to PrimeMail® at **888.214.1811**.

**Patient:** PrimeMail is your mail service pharmacy. Please make every attempt to obtain a new written prescription from your physician and send it with your Blue Cross order form and payment to:

**PrimeMail, P.O. Box 27836, Albuquerque, NM 87125-7836**

Follow these steps to obtain your prescription:

- Complete the Member, Patient and Payment Sections below using **black ink** only. A credit card number is required at the time the form is submitted.
- Ask your doctor to fill out the Prescription Section and fax this form to **888.214.1811**.
- Please allow 10 to 14 days for delivery from the date your physician faxes in your prescription.

**By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Blue Cross and Blue Shield's use or disclosure as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**



**DO NOT FAX PRESCRIPTIONS FOR CONTROLLED SUBSTANCES.**

## PRESCRIPTION SECTION

<b>Rx</b>	For _____	Date _____
	Address _____	Phone _____
Dr _____	Dr _____	
<small>Dispense as written</small>	<small>Substitution permissible, may substitute</small>	
Physician Name (Please print) _____		
Refills _____	Times _____	Address _____
DEA# _____	Phone _____	

MEMBER SECTION		
Member ID Number	Member Date of Birth	Group Number (copy from your ID card)
Member Name (First, M.I., Last)	Daytime Phone	Evening Phone
Address (please do not use a P.O. box)		E-mail Address
City	State	Zip
PATIENT SECTION		
Patient Name (First, M.I., Last if different from member)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Date of Birth
Patient E-mail Address		
DRUG ALLERGIES	HEALTH CONDITIONS	
<input type="checkbox"/> None Known <input type="checkbox"/> Sulfa <input type="checkbox"/> Aspirin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Codeine <input type="checkbox"/> Other Allergy _____ <input type="checkbox"/> Penicillin      _____	<input type="checkbox"/> None Known <input type="checkbox"/> Heart Condition <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Epilepsy <input type="checkbox"/> Ulcer <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other Condition _____	
Physician Name	Physician Phone	
<b>PrimeMail staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product, PrimeMail will dispense PFA-approved generic equivalents when available and appropriate.</b>		
PAYMENT SECTION		
Credit Card Number	Expiration Date (MM/YYYY)	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> Master Card <input type="checkbox"/> Visa	Credit Card Holder's Signature	