



SCOTT & WHITE
EXPRESS
HOME
PRESCRIPTION
SERVICES

Getting Started With Your New Prescription Benefit

Scott & White Prescription Services continues in the proud tradition of one century of outstanding patient care provided by the Scott & White family. Located in the heart of Texas, Scott & White is nationally recognized as a leader in managed health care.



SCOTT & WHITE EXPRESS OFFERS

- The Convenience of Home Delivery
- Up to 90 day supply* on maintenance medications
- Prescriptions filled within 1-2 business days of their receipt
- Lower cost for maintenance prescriptions

Before leaving our pharmacy, your order is verified by a registered pharmacist and sealed in tamper resistant packaging. The order is then forwarded to you via the US Postal Service.

Only the highest quality brand and generic medications are utilized by Scott & White Express Home Prescription Services for quality assurance you can depend on.

If you have any questions, please call or write to:

*Scott & White Prescription Services * P.O. Box 1287 * Salado, Texas * 1-800-707-3477 or 1-254-947-7555*

1. How do I get started?

A. Simply fill out the attached patient information form. Be certain to answer each question completely as this will help us to ensure rapid delivery.

B. Have your doctor write a new prescription requesting up to a 90 day supply*, plus refills whenever appropriate.

C. On the back of the prescription, please write the identification number and the date of birth of the member the prescription is for.

D. Send the completed form, your prescription and method of payment to Scott & White Express.

2. What if I need my prescription right away?

Have your doctor complete two prescriptions: one to be filled at your local pharmacy for a 30-day supply*, and a second with up to a 90 day supply* that you will include with your order to Scott & White Express.

3. After I have enrolled with Express, how do I order refills?

With each prescription order, the number of refills available (if any) is indicated. Reorder forms are provided with each shipment from Express. If refills are available, complete the reorder form and return it in the enclosed envelope, or call our toll-free line and use the automated reorder system.

4. How much will my prescription cost?

Prices and payments vary by the plan. Please call Express on our toll-free line and we will gladly quote your price on any new or refill prescriptions.

* Varies by plan.

It's that easy!

NEW MEMBER PRESCRIPTION ORDER FORM

Employer/Organization Name: _____

Subscriber Name:

Last

First

M.I.

Subscriber Identification Number: _____ - _____ - _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____)

To prevent accidental drug poisoning, all medications are dispensed in Child Resistant Packaging.

Please check if you would like NON Child Resistant Caps included with your order.

Number of new prescriptions enclosed: _____

Payment method: Visa Mastercard Discover American Express

Credit card number: _____ Expires: _____

Card Holder Name: _____

I certify that the information on this form is correct and all listed dependents are eligible for service as described by my prescription program. I authorize substitution of generic drugs when permissible in accordance with applicable law. Also, I authorize the release of all claim information to plan sponsors or administrators.

Date: _____ Signature: _____

Patient Profile Information	Comments
Please list all eligible members of your family. Attach additional information on a separate sheet if necessary. Complete the information below indicating any drug allergies or sensitivities	List any medical conditions, medications you are currently taking, and any other drug allergies in this section.
Name: Last, First, M.I. _____ Identification #: _____ Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U Physician: _____ Physician's Phone #: _____	
Name: Last, First, M.I. _____ Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U Physician: _____ Physician's Phone #: _____	
Name: Last, First, M.I. _____ Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U Physician: _____ Physician's Phone #: _____	
Name: Last, First, M.I. _____ Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U Physician: _____ Physician's Phone #: _____	