Welcome

to the benefits of the

APS Mail Order

CUSTOMER SERVICE
(877) 277-7934

Atlantic Prescription Services (APS) is pleased to provide you with a mail service benefit designed to provide you with your maintenance medications. Receive up to a 90 day supply of medications conveniently delivered to your home.

ORDER FORM (Part A)

Please complete the information o Parts A, B & C of this form (as appropriate). The health history grid (Part C) should be completed for each patient submitting a new prescription for the first time or to make changes for active patients.

It is important to include a telephone number in the Member Information area (Part B) in case we have questions about your order.

Please complete the payment options section (below). Failure to complete will result in a delay in the processing of your order.

Please use a black or blue pen to complete this form.
Our mailing address is: RxMPSS PHARMACY
5110 L STREET
OMAHA, NE 68117

TO FILL NEW PRESCRIPTIONS

(PLEASE INCLUDE YOUR HARD COPY PRESCRIPTIONS)

Patient Name	Date of Birth	Relationship			*(Check One)*		Brand Only*	Medication Name	Prescribing Physician Name
		Self	Spouse	Other	Fill Now	Place On File			
							☐		
							☐		
							☐		
							☐		

* I understand that generic drugs will be dispensed in all cases where legally permissible and medically appropriate, unless the above box I checked. By checking that box, a higher co-payment amount may apply.

PAYMENT OPTIONS

Payment to is due with each order. Do not send cash.

Delivery: Please allow 14 days from the date you mail your order for delivery of your medicine.

Credit Card (Our preferred payment method for faster service)

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Account # Expiration Date /

If you use a credit card for your payment, AmeriPharm will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Cardholder's Signature _____ Please keep this credit card on file for future orders.

Check # Money Order #

Check or Money Order Amount $.

Please write your cardholder ID number on your check or money order. There is a $30.00 returned check charge.

Delivery: Please allow 14 days from the date you mail your order for delivery of your medicine.

CUSTOMER SERVICE
877-APSRX-34

PHYSICIAN'S FAX LINE
402-342-4425

MEMBER INFORMATION (Part B)

(Please complete with each order using black or blue ink)

Cardholder ID# (Refer to ID Card)

Group # (Refer to ID Card if applicable)

Last Name of Cardholder

First Name of Cardholder

Delivery Address (Note: Check this box ____ if remaining information is same as previous orders and proceed to "Health History" section)

Street Address

Apt #

City

State

ZIP

Address above is for: (check only if applicable) ____ this order only ____ permanent address change

Daytime Phone Number – –

Evening Phone Number – –

Email Address

HEALTH HISTORY (Part C)

Please Complete This Health History Grid With Your First Order Or As Information Changes

Please complete information for you and all covered family members. If you are unsure about any health conditions, check with your Doctor. This portion will not be required on subsequent orders unless there have been changes in health or coverage status.

☐ Check here if information has changed.	Name (First, Middle, Last)	Birth date (MM/DD/YY)	M / F	No Known Allergy	Aspirin Allergy	Penicillin Allergy	Sulfa Allergy	Other Allergy	Diabetes	Epilepsy	Glaucoma	Heart Condition	High Blood Pressure	Thyroid	Ulcer
Member															
Spouse															
Dependent															
Dependent															
Dependent															
Dependent															

If you have additional dependents or require more space, please attach a separate note.

***Please indicate "Other Allergy"** _____

***Please indicate "Other Conditions"** _____

Over the counter medications / patient name _____

I represent that the information on this form is correct, and authorize the release of information regarding medical and prescription drug history and treatment to RxMPSS Pharmacy.

Signature _____ Date _____