MAIL ORDER PRESCRIPTION ENROLLMENT/UPDATE FORM

Please request mail order prescriptions 10 to 14 days before you need the medication.
Mail is not delivered on post office holidays. All controlled substances are mailed certified mail and will require signature upon receipt. Do not phone in or fax your order until you are ready for it to be mailed.

EMPLOYEE INFORMATION			
Name	Date of Birth	Employee ID#	Gender
Drug Allergies			
Mailing Address			
City	State	Zip	
Preferred Contact Number ( )	I'd like to receive notifications on the status of my prescriptions. □ Text (______)________________ *Note: You must text "Enroll" to 844-916-1925 □ Phone (______)________________ □ Email _________________________		

EMAIL ADDRESS *REQUIRED **(FOR ORDER STATUS AND TRACKING INFORMATION)**

PRESCRIPTION INSURANCE		
Payer/BIN:	Member ID	RX Group #

List family members on HH Health Plan that will receive mail order. Include a direct phone number to any adult listed.

Name: DOB: Allergies:	Phone number (______)_______________ I'd like to receive notifications on the status of my prescriptions. □ Text (______)________________ *Note: You must text "Enroll" to 844-916-1925 □ Phone (______)________________ □ Email _________________________
Name: DOB: Allergies:	Phone number (______)_______________ I'd like to receive notifications on the status of my prescriptions. □ Text (______)________________ *Note: You must text "Enroll" to 844-916-1925 □ Phone (______)________________ □ Email _________________________
Name: DOB: Allergies:	Phone number (______)_______________ I'd like to receive notifications on the status of my prescriptions. □ Text (______)________________ *Note: You must text "Enroll" to 844-916-1925 □ Phone (______)________________ □ Email _________________________

PAYMENT METHOD *REQUIRED (PAYMENT INFORMATION WILL REMAIN ON FILE)

Credit Card Visa MasterCard AMEX Discover

Cardholder Name	Card number	Expiration Date (MM/YYYY)

I hereby authorize Huntsville Hospital Mail Order Pharmacy to bill my credit/debit card for this and all future orders. I understand that my credit/debit card will be billed at the time my order is filled.

Cardholder Signature: **Date:**

AUTHORIZATION

By signing below, I certify that the information on this form is correct, and I authorize the release of information regarding my medical and prescription drug history to Huntsville Hospital Mail Order Pharmacy.

Employee Signature: **Date:**

Email, Mail, or Fax completed form to:

HH Pharmacy St. Clair- 1963 Memorial Parkway SW, Ste 15, Huntsville, AL 35801

Phone (256)265-3900 * Fax (844) 213-1898 * mail.order.pharmacy@hhsys.org

We regretfully cannot accept faxed or photocopied prescriptions from patients. To avoid delays, please give our phone and fax number to your doctor's office. If mailing a prescription, please submit completed form with the original prescription in an envelope to the address above.