



Mail this form to:

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



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Visit www.MyPrimeMail.com
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Hearing Impaired TTY/TDD 866.346.7197

CARD HOLDER INFORMATION

Card Holder's ID

Grid for Card Holder's ID

Last Name

Grid for Last Name

First Name

Grid for First Name

MI

MI Grid

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Date of Birth Grid

Phone Number

Phone Number Grid

Permanent Address

Grid for Permanent Address

City

Grid for City

State

State Grid

ZIP Code

ZIP Code Grid

Email Address

Grid for Email Address

Contact by: Email Phone

Prescriber Last Name

Grid for Prescriber Last Name

Drug Allergies

- None Codeine Sulfa
Aspirin Erythromycin Penicillin
Other

Prescriber Phone Number

Grid for Prescriber Phone Number

Health Conditions

FAMILY MEMBER #1 INFORMATION

Last Name

Grid for Last Name

Drug Allergies

- None Codeine Sulfa
Aspirin Erythromycin Penicillin
Other

First Name

Grid for First Name

MI

MI Grid

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Date of Birth Grid

Health Conditions

Prescriber Last Name

Grid for Prescriber Last Name

Prescriber Phone Number

Grid for Prescriber Phone Number

FAMILY MEMBER #2 INFORMATION

Last Name

Grid for Last Name

Drug Allergies

- None Codeine Sulfa
Aspirin Erythromycin Penicillin
Other

First Name

Grid for First Name

MI

MI Grid

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Date of Birth Grid

Health Conditions

Prescriber Last Name

Grid for Prescriber Last Name

Prescriber Phone Number

Grid for Prescriber Phone Number

Total Number of New Prescriptions:

Mail the original physician-signed prescriptions with this form.

FAMILY MEMBER #3 INFORMATION

Last Name

First Name

MI

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Prescriber Last Name

Drug Allergies

- None Codeine Sulfa
 Aspirin Erythromycin Penicillin
 Other _____

Health Conditions _____

Prescriber Phone Number

SHIPPING INFORMATION

Standard postal: No charge **Second business day:** \$9* **Next business day:** \$15*

***Additional costs for expedited shipping.**

Shipping time does not include processing time. We are unable to ship to P.O. boxes for second business day or next business day shipping. Shipping address must be a physical location.

Alternate Shipping Address (if different than permanent address)

City

State

Zip Code

Phone Number

This is a change of address This is a one time address Seasonal address from _____ to _____

PAYMENT INFORMATION

Payment is due with each order and may be made by credit card, check or money order. Orders received without payment will delay processing. There is a \$20 returned check charge.

Check or money order

Please make check or money order payable to PrimeMail and include your member ID on the memo line. Do not send cash.

Check Money Order

Credit card information

To authorize payment by credit card, provide the account number, expiration date and signature. We accept Discover, MasterCard, VISA and American Express. This card will be used for this and all future orders unless we are notified otherwise.

Credit Card Number

Expiration Date

Use credit card on file, with the last 4 digits of:

Signature _____

Date _____

Pharmacy law permits pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your prescriber indicate otherwise. Some health plans require the patient to pay the difference between generic and brand name cost.

By returning this form to PrimeMail, you consent to the release and use of the patient's health information to the patient's health plans and health care providers/agents for health benefits management. PrimeMail's use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers; shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

PrimeMail may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product.

Blue Shield of California is an independent Member of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans. Prime Therapeutics LLC is an independent company that provides pharmacy mail services for covered maintenance drugs on behalf of Blue Shield of California.



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First Name

Grid for First Name and MI

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Grid for Date of Birth

Phone Number

Grid for Phone Number

Permanent Address

Grid for Permanent Address

City

Grid for City

State

ZIP Code

Grid for State and ZIP Code

Email Address

Grid for Email Address

Contact by: Email Phone

Physician/Prescriber Last Name

Grid for Physician/Prescriber Last Name

Drug Allergies

- None Codeine Sulfa
Aspirin Erythromycin Penicillin
Other

Physician/Prescriber Phone Number

Grid for Physician/Prescriber Phone Number

Health Conditions

FAMILY MEMBER #1 INFORMATION

Last Name

Grid for Last Name

Drug Allergies

- None Codeine Sulfa
Aspirin Erythromycin Penicillin
Other

First Name

Grid for First Name and MI

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Grid for Date of Birth

Health Conditions

Physician/Prescriber Last Name

Grid for Physician/Prescriber Last Name

Physician/Prescriber Phone Number

Grid for Physician/Prescriber Phone Number

FAMILY MEMBER #2 INFORMATION

Last Name

Grid for Last Name

Drug Allergies

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Aspirin Erythromycin Penicillin
Other

First Name

Grid for First Name and MI

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Grid for Date of Birth

Health Conditions

Physician/Prescriber Last Name

Grid for Physician/Prescriber Last Name

Physician/Prescriber Phone Number

Grid for Physician/Prescriber Phone Number

REFILL BY MAIL

| <div style="display: flex; justify-content: space-between; font-size: small;"> Prescription Card Holder Family Member 1 Family Member 2 </div> | | | | Patient Name | Physician Name/Phone Number/Drug Name | Prescription Numbers (for refills only) | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------|---------------------------------------|--|--|--|--|--|--|
| 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |
| 4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | |

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