Mail Order Registration Form

Your Location Name: _____ Facility #: _____

Use this form to register for mail order pharmacy services.
Fill this PDF on your computer or print form and complete by hand.
Please have your physician call in a 90 day supply of each medicine.
e-prescribe: PruittRX-Norcross

MEMBER INFORMATION

Not all ID and Group Number boxes may be needed.

☐ Male ☐ Female Date of Birth [MM/DD/YYYY]:_____ SSN: _____

Member ID Number *(Located on card)*:_____ Suffix *(If on card)*: _____ Group Number:_____

Email Address *(To receive information regarding the processing of your order)*: _____

Last Name: _____ First Name: _____

Home Phone: _____ Mobile Phone: _____

Shipping Address: _____ Apt or mailbox #: _____

City: _____ State: _____ ZIP Code: _____

MEMBER

Allergies	Order Preference
○ Aspirin ○ Cephalosporin ○ Codeine derivatives ○ Morphine derivatives ○ Penicillin ○ Sulfa drugs ○ None known ○ Other (use lines below) _____ _____ _____	○ Easy-open caps ○ Automatic refill* **You must notify the pharmacy to remove discontinued medications from automatic refill.*

Brand names are the property of their respective owners.

PAYMENT INFORMATION

Note: You will only be notified if your order is $200 or over prior to shipping.

Payment Options: *Payment is required at time of order.*
Please do not send cash.
We accept Discover®, MasterCard®, American Express®, and Visa®.

This card will be placed on file for this and all future orders.
Please notify us of any payment method changes.

☐ Discover ☐ MasterCard ☐ American Express
☐ Visa ☐ FSA/HSA Card

Credit Card Number: _____

Expiration Date [MM/YY]: _____ CVV Code: _____

I authorize PruittHealth Pharmacy Services to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my balance and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature: _____

Date: _____

☐ Payroll deduction

I authorize the deduction from my paycheck of the amount of my prescription purchase from PruittHealth Pharmacy Services (Norcross). I understand that if my employment is terminated prior to paying for prescriptions received, the company will recoup any amount due from my final paycheck to the extent allowed by law. I understand that upon termination I am responsible for payment of any outstanding balance not covered by payroll deduction.

Partner Signature: _____

Date: _____

PruittHealth
PHARMACY SERVICES

DEPENDENT INFORMATION

PLEASE FILL OUT A SEPARATE FORM FOR EACH DEPENDENT. You may save this form, make photo copies, or download additional forms at https://pruitthealth.com/our-company/partner-services

☐ Male ☐ Female Date of Birth [MM/DD/YYYY]:_____ SSN: _____

Member ID Number *(Located on card)*:_____ Suffix *(If on card)*: _____ Group Number:_____

Email Address *(To receive information regarding the processing of your order)*: _____

Last Name: _____ First Name: _____

Home Phone: _____ Mobile Phone: _____

☐ Shipping information is the same as Member ☐ Shipping information is the NOT the same as Member, see below

Shipping Address: _____ Apt or mailbox #: _____

City: _____ State: _____ ZIP Code: _____

DEPENDENT

Allergies		Order Preference
○ Aspirin	○ Penicillin	○ Easy-open caps
○ Cephalosporin	○ Sulfa drugs	○ Automatic refill
○ Codeine derivatives	○ None known	
○ Morphine derivatives	○ Other (use lines below)	**Notify the pharmacy to remove discontinued medications from automatic refill.*
_____		
_____		

1. **Allow 7-14 business days from receipt of prescription for medications to arrive.**
2. **Any missing or illegible information may lead to a delay in delivery.**
3. **Notify PruittHealth Pharmacy Services (Norcross) with any change of address, payment type or any other information to avoid delay in delivery. PruittHealth Pharmacy Services and PruittHealth Partner Services are not synced.**
4. **Complete payment information on back of this form to avoid delay in delivery.**
5. **Medicine cannot be returned to pharmacy once it has been shipped.**

Standard Ground Delivery is provided at no charge. Special delivery requests are available at additional charge. **Please allow 7-14 business days from the time that you place your order to receive your prescription(s).**

Items that require refrigeration will be shipped via FedEx and tracking information will be emailed.

It is standard pharmacy practice to substitute generic equivalents for brand-name medications. PruittHealth Pharmacy Services will dispense an FDA-approved generic equivalent if available, permitted by your prescriber and allowed by state law. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Support Line at (855) 628-4660.

By submitting this form, you have authorized release of all information to PruittHealth Pharmacy Services and other necessary parties as required to process your order under your benefit plan.

PruittHealth PHARMACY SERVICES

Fax: (877) 508-1116 • Phone: (855) 628-4660 • Email: Refills@PruittHealth.com
e-prescribe: PruittRX-Norcross

NAVITUS

NAVITUS is your prescription drug insurance provider.
Please direct all co-pay questions directly to them at 844-268-9789