AllHealth NETWORK PHARMACY

Mailing/Home Delivery Enrollment Form

Home delivery or mailing is a convenient and cost-effective way for you to receive your medication at your home, office or location of your choosing. You will minimize trips to the pharmacy and save time waiting for your medications. With home delivery service from AllHealth Network Pharmacy, your medicine arrives safely at your door in plain packaging—at no extra cost to you.

Delivery methods & rates listed below are subject to change. Estimated delivery time is a sum of processing time (1-2 business days on average, may be up to 5 days if additional information is needed from your doctor) plus shipping time. Various shipping policies & exceptions may also apply to your order, depending on the items ordered.

Delivery Options

☐ Mailing

☐Standard (Free) Takes up to 5 days after your order is processed.

If you want faster delivery, choose:

☐2nd Day ($12.95)

☐Next Day ($19.95)

Faster delivery can only be sent to a street address, not a PO Box

☐Delivery (courier)

Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.

You may request refills online at https://www.allhealthnetwork.org/services/pharmacy or use our RxLocal app 24 hours a day, 7 days a week.

Delivery / Shipping Information

Name ____

Street Address ____ Apt. /Suite# ________________

City _______________________________________ State __________ Zip Code ____________-___________

Daytime Phone # ______________________________ Evening Phone # _______________________________

Payment Options

Payment will be required in advance for co-pays or other non-covered items. You may put money on an account in advance, pay with a credit or debit card by phone or provide a credit/debit card to keep on file for future orders.

Billing Information: ☐ Check here if same as shipping address

Name ____

Street Address ____ Apt. /Suite# ________________

City __________________________________ State ____________ Zip Code _____________-____________

Daytime Phone # ___________________________________ Evening Phone # ________________________________

☐ Credit Card—you authorize AllHealth Network Pharmacy to charge your credit card to pay for each pharmacy order. Charge dates and amounts will vary with each order. We accept: American Express, Visa, MasterCard and Discover

Prior to delivery or mailing, please speak to pharmacy staff to provide your credit/debit card information or to place your credit/debit card on file.

I hereby authorize AllHealth Network 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.

Signature ____

☐ Check here if you **DO NOT** want us to use this payment method for future orders.

Miscellaneous

AllHealth Network Pharmacy wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want a generic equivalent, please check the box below.

☐ No Generics

> *Note: By checking this box I understand that, depending on my plan benefits, I may be responsible for the brand co-payment, which may be higher, and any plan penalties that may apply.*

☐ Easy-Open Caps

- ☐Yes
- ☐No

We may package all of your prescriptions together unless you tell us not to.

All prescriptions submitted to the AllHealth Network Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your insurance, do not use this form. You may call the Pharmacy to make alternate arrangements for submission of your order and payment.

Enroll additional family members

If you have additional family members in your home that would like to have medications delivered, please provide their information below. Shipments for multiple family members may be delivered in the same package unless you click the box below.

Family members signing below, authorize AllHealth Network Pharmacy to package their medications with other family members' medications for mailing/delivery. Bundled shipments cannot be processed until all signatures/authorizations have been obtained.

Name: DOB: Allergies: Phone #:

Signature:
Name: DOB: Allergies: Phone #: Signature:
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☐ Do **<u>Not</u>** include other family member's medications in one package. Please mail each person's medications in a separate package.

Restrictions

Due to federal regulations, we can only ship to addresses within the U.S., & some medications are not eligible for home delivery. Please see Policies & Exceptions below for more information.

Policies & exceptions

- Some items require special shipping & handling. The most common exceptions are listed below, but other policy restrictions may apply.
    - **New prescriptions:** If your healthcare provider does not call your prescription in to us directly, we will verify orders for new prescriptions before we fill them. Depending on the verification time & the shipping method you select, you can expect to receive your medication in 3-10 business days.
    - **Controlled substances:** AllHealth Network Pharmacy ships all controlled substances express 2nd day with an adult (18 years or older) signature required.
    - **Hazardous or regulated items:** Some prescription medications, including aerosol inhalers, cannot ship by air because they could interfere with flight safety. These orders must ship ground via Standard Shipping in the 48 contiguous states & cannot be shipped to Alaska, Hawaii or destinations outside the U.S.
    - **Special prescription deliveries:** If your order contains refrigerated medications, our policy is to ship them via Express delivery, packaged with a cold gel pack, to all addresses except APO/FPOs, to assure that they ship at the proper temperature. We require an adult signature (18 years or older) for delivery of these medications.

Authorization

I agree that the information on this form is correct, and authorize release of all information regarding my medical and prescription drug history and treatment to AllHealth Network Pharmacy. I understand that my prescription order(s) will be fulfilled and shipped upon receipt of my complete enrollment form, prescription(s) and applicable payment. Additionally, I understand that it is my responsibility to update my address with the pharmacy if my preferred mailing address changes. By signing this consent form, I am indicating that I fully understand the attestation and that I agree to have prescriptions mailed to the address specified above.

____ ____________________________

Signature Date