

To ensure fast delivery, please verify your prescriptions before you leave the physician's office to make certain that:

- The physician's name is legible
- The patient's name is legible
- The exact daily dosage is specified
- The exact strength is specified
- A 90-day supply quantity is indicated
- The number of refills will last for 1 year

Refill by Phone

Call ProCare Pharmacy Care's Refill by Phone Interactive Voice Center at: 800-662-0586 using a touchtone phone. Please have the prescription number, which is located on the prescription bottle, available when calling.

Refill by Mail

With your first order, we will send you a "Prescription Order Form" to be used when ordering refills.

- Complete all sections on the form
- Affix the ProCare Rx refill label(s) in the space provided (sample shown below)
- Enclose payment amount (if applicable)
- Mail your request using the enclosed envelope

Refill Labels are provided with your prescription receipt.

Rx: 001567 02/05/10

REFILL LABEL



Refills by Internet

To refill prescription(s) online, simply complete the Refill Request Form that is located at www.ProCareRx.com under the "Mail Order" option listed on the website.
(Click on the mail order tab at the top of the page)

Call Customer Care Toll-Free at:

800-662-0586

TTY Line 800-798-5082

ProCare Pharmacy Care

3891 Commerce Parkway

Miramar, FL 33025

Fax: 800-662-0590

HomeDelivery@ProCareRx.com



Prescription Order Form and Patient Profile for New Members

800-662-0586

TTY Line 800-798-5082

HomeDelivery@ProCareRx.com

Enjoy These Benefits

A 90-day supply of your medication may be available at a lower copay than you would pay at your retail pharmacy. Refilling your prescription is easy when using the following options:

Website: www.ProCareRx.com

(Click on the mail order tab at the top of the page)

Mail: 3891 Commerce Parkway
Miramar, FL 33025

Phone: 800-662-0586

For faster service on a new prescription,
ask your physician to call
800-662-0586 or fax to **800-662-0590**

All prescriptions are screened for potential interactions and allergy sensitivity based on the information you provide in your patient profile.

Order Form for New Participants:

Prescriptions are for:

Member Spouse Dependent



Member #: _____

Please write the Member ID, Date of Birth, and your address on the back of each prescription.

Check here if you would like non-childproof caps with your order. *(Childproof caps are used on all prescription orders for safety during shipping)*

Payment Method

Check (Make payable to "ProCare Pharmacy Care")

Money Order Visa MasterCard

Name (as it appears on card): _____

Account #: _____

Signature: _____

Expiration Date: _____ Date: _____

Check here if you do not want future orders charged to this credit card which will be placed on file

Check here to opt out of auto-refill program

Patient Profile and Order Form

Instructions for new members: First time users of ProCare Pharmacy Care Mail Order Pharmacy program must complete all sections of this form.

Member Name: _____ Date of Birth: _____ Male Female

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone _____ Best time to call: _____

Alternative Phone: _____ email address: _____

By providing your email address you are granting ProCare Rx permission to contact you via email regarding your prescription drug coverage.

Allergies: None Penicillin Erythromycin Sulfa Aspirin Other: _____

Health Conditions: Asthma Cholesterol Depression Diabetes Heart Failure Thyroid
 Stomach Ulcer/Reflux High Blood Pressure Other: _____

If Diabetic, indicate brand used for diabetic supplies:

Monitor: _____ Lancets: _____ Test Strips: _____

Spouse Name: _____ Date of Birth: _____ Male Female

Allergies: None Penicillin Erythromycin Sulfa Aspirin Other: _____

Health Conditions: Asthma Cholesterol Depression Diabetes Heart Failure Thyroid
 Stomach Ulcer/Reflux High Blood Pressure Other: _____

If Diabetic, indicate brand used for diabetic supplies:

Monitor: _____ Lancets: _____ Test Strips: _____

Dependent Name: _____ Date of Birth: _____ Male Female

Allergies: None Penicillin Erythromycin Sulfa Aspirin Other: _____

Health Conditions: Asthma Cholesterol Depression Diabetes Heart Failure Thyroid
 Stomach Ulcer/Reflux High Blood Pressure Other: _____

If Diabetic, indicate brand used for diabetic supplies:

Monitor: _____ Lancets: _____ Test Strips: _____

CERTIFICATION – PLEASE READ AND SIGN: I CERTIFY THAT THE INFORMATION PROVIDED IN THIS FORM IS CORRECT, AND I AUTHORIZE THE RELEASE OF ALL INFORMATION TO THE HEALTH INSURANCE PLAN, ADMINISTRATOR, OR UNDERWRITER. I AUTHORIZE PROCARE PHARMACY CARE TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE IN ACCORDANCE WITH APPLICABLE LAW, AND CONSISTENT WITH THE DOCTOR'S ORDERS.

Signature _____

Date _____