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 our Refill by Phone Interactive Voice Center at: 800-662-0586 using a touch tone phone. Please have the prescription number, which is located on the prescription bottle, available when calling.

**Refills by Internet**

To refill prescription(s) online, simply complete the Refill Request Form that is located at www.procarerx.com. Choose the ‘Mail Order Refills’ option listed on the left-hand side of the page under the Quick Links panel.

**Refill by Mail**

- Complete all sections on the reverse side.
- Enclose payment amount (if applicable).
- Mail your request using the enclosed envelope to:
  
  ProCare PharmacyCare
  2650 SW 145th Avenue
  Miramar, FL 33027

**HomeDelivery@ProCareRx.com**

Customer Care Center:

**800-662-0586**

Fax: 800-662-0590

TTY Line: 711

Monday through Friday
8:00 am to 8:00 pm (ET)
Saturday 9:00 am to 1:00 pm (ET)

HomeDelivery@ProCareRx.com

**ProCare PharmacyCare**

Miramar, FL

**HST Pharmacy**

Gainesville, GA

**800-662-0586**

TTY Line: 711

HomeDelivery@ProCareRx.com
**Patient Profile and Order Form**

Instructions for new members: first time users of ProCare PharmacyCare’s Home Delivery program must complete all sections of this form.

<table>
<thead>
<tr>
<th>Member name: ________________________</th>
<th>Date of birth: ________</th>
<th>Male  Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: ______________________________</td>
<td>Apt. #: ________________</td>
<td></td>
</tr>
<tr>
<td>City: ________________________________</td>
<td>State: ______ Zip: ______</td>
<td></td>
</tr>
<tr>
<td>Home phone: _________________________</td>
<td>Cell phone: ____________</td>
<td>Best time to call: ______</td>
</tr>
<tr>
<td>Alternative phone:__________________</td>
<td>Email address: ___________</td>
<td></td>
</tr>
</tbody>
</table>

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: ______________________

<table>
<thead>
<tr>
<th>Spouse name: _________________________</th>
<th>Date of birth: ________</th>
<th>Male  Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: ______________________________</td>
<td>Apt. #: ________________</td>
<td></td>
</tr>
<tr>
<td>City: ________________________________</td>
<td>State: ______ Zip: ______</td>
<td></td>
</tr>
<tr>
<td>Home phone: _________________________</td>
<td>Cell phone: ____________</td>
<td>Best time to call: ______</td>
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**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 PHARMACYCARE, LLC OR HST PHARMACY TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE IN ACCORDANCE WITH APPLICABLE LAW, AND CONSISTENT WITH THE DOCTOR’S ORDERS.

__________________________ ________________________
Signature Date