

**3 Refill Information** *This section is for prescriptions you have filled with DrugSource in previous orders.*

Use my address on file     Ship to Alternate Address \_\_\_\_\_

Patient Name		DOB	/ /	Rx#		Med	
Patient Name		DOB	/ /	Rx#		Med	
Patient Name		DOB	/ /	Rx#		Med	
Patient Name		DOB	/ /	Rx#		Med	
Patient Name		DOB	/ /	Rx#		Med	
Patient Name		DOB	/ /	Rx#		Med	
Patient Name		DOB	/ /	Rx#		Med	
Patient Name		DOB	/ /	Rx#		Med	

**Remember:** You can log onto [www.drugsourceinc.com](http://www.drugsourceinc.com) or call our automated refill line **(800) 854-8764** for easy access to refill your medications

**4 Contact Physician/Transfer Information** *Fill out section below if you would like us to contact your physician or your previous pharmacy\* for prescriptions*

Medication Name/Rx #	Strength	Quantity	Prescription Directions	Doctor Information	Fill	Fill	Patient Name
					Now	Later	
				Name Phone Fax			
				Name Phone Fax			
				Name Phone Fax			
				Name Phone Fax			

*\*Note: We will need your previous prescription numbers from your pharmacy to transfer. If there are no refills, we will contact your doctor.*

Please contact Physician  
 These are transfers from my previous pharmacy    Pharmacy Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**5 Payment Information** *Check the box to choose the type of payment you would like to use for your order.*

Electronic Check. *Include a voided check or its copy.*      Amount of Co-payment \$ \_\_\_\_\_

Check/Money Order Enclosed    Check# \_\_\_\_\_  
 (\$20 returned check service charge will apply)      *Please contact us if you have any questions about how much you should enclose/what your co-pay is.*

Credit/Debit/FSA Card

Use Credit Card on file                        CVV Code Security Code \_\_\_\_\_

This is a New Credit Card                 Exp Date   /

Keep On File     One Time Use

I certify that all information entered on this form is correct and that the named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, and sponsor in accordance with the Health Insurance Portability and Accountability Act (H.I.P.A.A).

Signature X \_\_\_\_\_ Date \_\_\_\_\_

# DRUGSOURCE, INC.

## Patient Profile Form



*We care about the needs of our customers. That's why we offer home delivery of every product we sell.*

### Place Orders by

Mail    Phone    Fax\*    Email

*\*Prescriptions may be faxed by physician ONLY*

We also carry:

**Durable Medical Equipment**    **Over-the-Counter Products**    **Ostomy Products**    **Wound Care Products**

## DRUGSOURCE, INC.

PO BOX 1366  
 Elk Grove Village, IL 60009  
 (800) 854-8764  
 Fax (847) 258-1913  
[www.drugsourceinc.com](http://www.drugsourceinc.com)

*VIPPS Accredited by the National Association of Boards of Pharmacy*

## Frequently Asked Questions

### How do I start filling prescriptions with DrugSource?

Complete this patient profile form and mail it in with your maintenance prescription(s) written for a 90-day supply  
OR

Log onto [www.drugsourceinc.com](http://www.drugsourceinc.com) to complete the online patient profile form. You can either mail in the paper version of your prescription(s) or fill out a request for us to fax your physician

(\*Note: Some physicians may require you to mail in the written prescription. Please check with your doctor's office.)

### What is the turn-around time for my prescriptions?

Please allow 10 to 14 business days to receive your order.  
(This time may vary).

### How can I refill my prescriptions?

Complete the Section 3 of this form and mail it in  
OR

Log onto [www.drugsourceinc.com](http://www.drugsourceinc.com) and click "Refill Order / Status" (have the DrugSource prescription number and Date of Birth of the patient handy)

OR

Call 800/854-8764 to speak to our customer service team or use our automated touch-tone refill line

OR

Fax in your refills to 847/258-1913

### What if my prescription is out of refills?

Call our customer service team and we can contact your physician

OR

Log onto [www.drugsourceinc.com](http://www.drugsourceinc.com). Click Refill Order / Status. Click on View Medication History and click the prescription you would like to refill. If the prescription is expired/needs refills, we will contact your physician.

OR

Mail in another written prescription with the patient's name and Date of Birth printed on its back

OR

Have the doctor fax in a prescription to 847/258-1913  
(Prescriptions may **ONLY** be faxed by the physician's office)

**Please Note:** Each state has its own laws regarding Class II Narcotic Prescriptions. Please contact us if you have any questions.

## Patient Profile Form

### 1 Employee Information

Please fill in all areas with the required information.

This is **NEW** information.  
Please update my profile.

Company Name		Group Number	
I.D. Number		Bin Number	

Cardholder's Name (Please Print) \_\_\_\_\_

Address \_\_\_\_\_  
First Middle Last  
 \_\_\_\_\_  
Street Apt #  
 \_\_\_\_\_  
City State Zip Code

Phone (\_\_\_\_) \_\_\_\_\_

Daytime (\_\_\_\_) \_\_\_\_\_

Shipping Address, if different \_\_\_\_\_

Cardholder's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_     Male     Female    Are you pregnant at this time?     Yes     No

Describe Cardholder's drug allergies/medical conditions: Check here if none:

I authorize DrugSource to dispense generic medication.

Yes     No

I understand that refusal of generics may impact my co-payment.

List Prescription (RX)/OTC Medications you are currently taking (including RXs DrugSource has not filled):  
Attach additional paper, if necessary.

Print Name of Physician ordering medications \_\_\_\_\_

Physician Phone Number (\_\_\_\_) \_\_\_\_\_    Physician Fax (\_\_\_\_) \_\_\_\_\_

Please send me an email notice when my package is shipped.     Please correspond with me about orders through this email.

EMAIL ADDRESS \_\_\_\_\_

### 2 Dependent Information

If you have no eligible dependents, check here --

Name \_\_\_\_\_     Spouse     Dependent

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_     Male     Female

Drug Allergies / Medical Condition \_\_\_\_\_    Doctor's Name \_\_\_\_\_

List Rx's/OTC Meds Currently Taking: \_\_\_\_\_

Name \_\_\_\_\_     Spouse     Dependent

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_     Male     Female

Drug Allergies / Medical Condition \_\_\_\_\_    Doctor's Name \_\_\_\_\_

List Rx's/OTC Meds Currently Taking: \_\_\_\_\_

Name \_\_\_\_\_     Spouse     Dependent

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_     Male     Female

Drug Allergies / Medical Condition \_\_\_\_\_    Doctor's Name \_\_\_\_\_

List Rx's/OTC Meds Currently Taking: \_\_\_\_\_