

PRESCRIPTION ORDER FORM



**AFFINITY
PHARMACY**

Please fill out the following form and fax to the Affinity Pharmacy of your choice.

Last Name: _____ First Name: _____ M. Initial: _____

Date of Birth: _____ Member ID Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Other: _____

Email Address: _____ SSN: _____

Allergies: _____

PRESCRIPTION INFORMATION

Please check the box to indicate how you prefer to receive your prescriptions.

Transfer and mail my prescriptions using my credit/debit card to pay any and all charges

Transfer my prescriptions and I will pick up at the retail location I've selected below:

Affinity Pharmacy at Saint John (APS)

Affinity Pharmacy at Oliver Road (APO)

See back for contact information for each Affinity Pharmacy, as well as an informational chart to help select which option better takes care of your prescription needs. You can call the Affinity Pharmacy of your choice with your prescription information to transfer your medications. We can charge your debit or credit card for the applicable copay and shipping charges. **Shipping is free for Vantage Members.**

Please allow 48 hours to transfer and process the prescription(s) and an additional 2-3 days for the U.S. Postal Service to deliver.

Medication Name: _____ Prescription Number: _____

Pharmacy Name and Phone Number: _____

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Pharmacy Name and Phone Number: _____

If you have more prescriptions, please use the allotted section on the back of this form or attach another page with the information on each.

BILLING INFORMATION

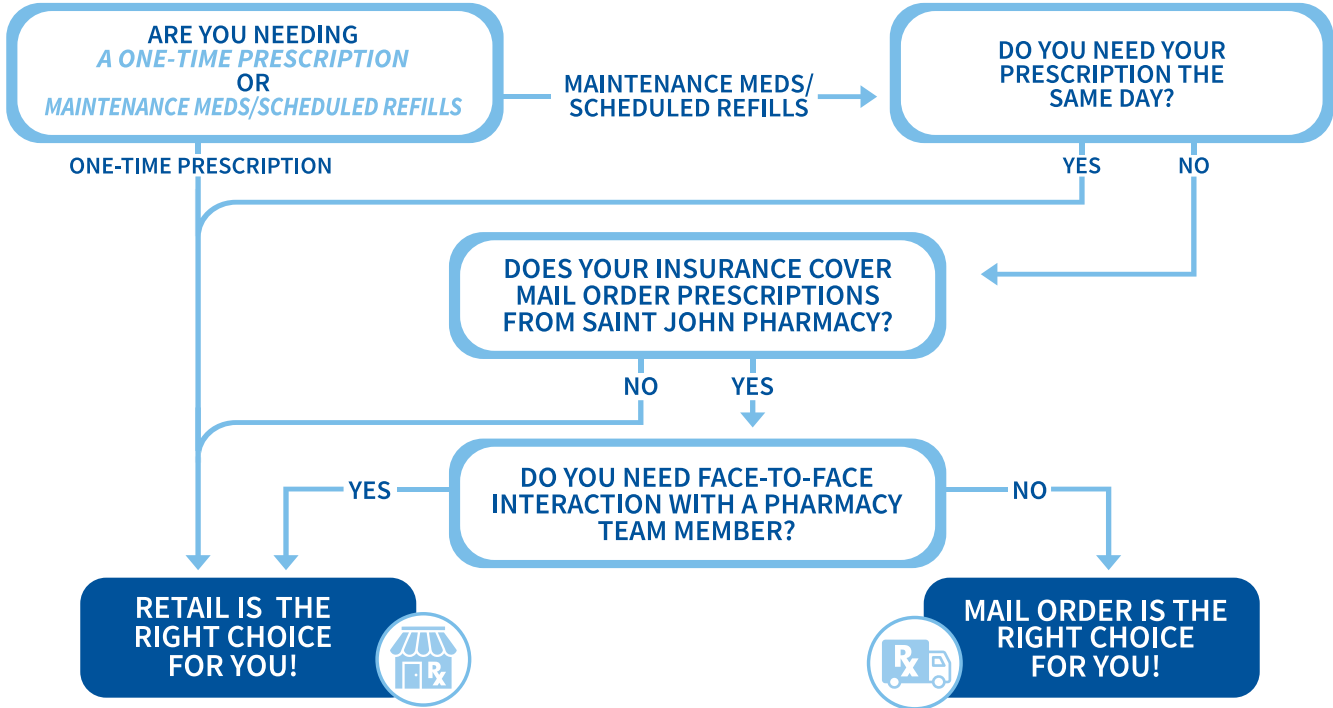
Check credit card type or include a copy: Visa® MasterCard® Discover® American Express®




Credit Card Number: _____ Expiration Date: _____

By signing below, I authorize Affinity Pharmacy to use the credit card information listed to provide payment on any outstanding balance.

Cardholder Signature: X _____ Date: _____

START HERE



RETAIL		MAIL ORDER
 <p>AFFINITY PHARMACY <i>at St. John</i></p> <p>110 St. John Street Monroe, LA 71201</p> <p>Phone: 318-807-4770 Toll-Free: 1-844-834-8839 Fax: 318-807-1831 APS@ahgphysician.com</p>	<p>AFFINITY PHARMACY <i>at Oliver Road</i></p> <p>920 Oliver Road <i>(Waiting Room E)</i> Monroe, LA 71201</p> <p>Phone: 318-807-6254 Toll-Free: 833-969-2896 Fax: 318-812-7346 APO@ahgphysician.com</p>	 <p> SAINT JOHN PHARMACY</p> <p>Phone: 318-807-1083 Toll-Free: 888-316-4354 Fax: 318-807-1079 SJP@ahgphysician.com</p>

ADDITIONAL PRESCRIPTIONS

Use the following space to continue listing prescription medications from the front. If more space is needed, attach additional sheets.

Medication Name: _____ Prescription Number: _____
 Pharmacy Name and Phone Number: _____

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 Pharmacy Name and Phone Number: _____

Medication Name: _____ Prescription Number: _____
 Pharmacy Name and Phone Number: _____

Medication Name: _____ Prescription Number: _____
 Pharmacy Name and Phone Number: _____

Medication Name: _____ Prescription Number: _____
 Pharmacy Name and Phone Number: _____