Times Pharmacy *Mail Options*

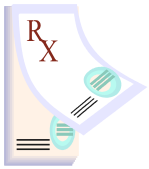
It's easy and convenient to get your prescriptions from the Times Pharmacy Mail Options.

To take advantage of the convenience and savings, simply follow these 3 easy steps:

Step 1: Fill out the Times Pharmacy Mail Options Form.

Please complete parts A, B, C, D, E, F, and G of the Mail Order Form.

Step 2: Talk to your physician



- Tell your physician you would like to get your maintenance medication(s) delivered to your home through Times Pharmacy Mail Options.
- Be sure to ask for a 90-day supply on your prescription with up to 3 refills to maximize your savings.
- You can also have your physician complete our Times Pharmacy Mail Options Prescriber Fax Form.

Please Note: Maintenance medications are drugs that are taken on a regular basis for a long-term health condition.

Step 3: Send us your Form and Prescriptions:

- Mail the Order Form or

Return the Mail Order Form in an envelope along with any new original written prescriptions to:

Times Pharmacy Mail Options
1425 Liliha Street
Honolulu, HI 96817

- Have your physician fax your form and prescription to Times Pharmacy Mail Options Toll Free Fax Line - 643-4436.

Step 4: Need a prescription **REFILL, Call Toll Free 643-6337.**

Questions?? Please call toll-free 643-6337 and we can help you get started with Times Pharmacy Mail Options!!

Mail Options Form & Patient Profile

Times Pharmacy dispenses federally approved, generic medications for brand-name medications unless you or your physician directs otherwise.

Please print clearly. Put a "√" in applicable boxes.

PART A: PATIENT INFORMATION (One form per patient)

Date of Birth [MM/DD/YYYY] ☐☐ / ☐☐ / ☐☐☐☐ ☐ Male ☐ Female

Last Name | First Name | Middle Initial | Suffix

Street Address | Apt No. | Daytime Phone

City | State | ZIP Code | Evening Phone

Driver's License Number/Government Issued ID Number or Social Security Number | State Issued | Cell Phone

Email Address

Easy-open Caps: ☐ Yes ☐ No

Auto Refill: ☐ Yes ☐ No

PART B: INSURANCE INFORMATION

Name of Insurance | Cardholder's ID Number | Group Number

Bin Number | PCN Number (If applicable) | Cardholder's Date of Birth

Cardholder's LAST Name | Cardholder's FIRST Name | Middle

☐ Male ☐ Female ☐ Photo Copy of Insurance Card attached (optional, but preferred**)

Other insurance coverage INCLUDING MEDICARE coverage

Name of Insurance | Cardholder's ID Number | Group Number

BIN Number | PCN Number (If applicable) | Cardholder's Date of Birth

Cardholder's LAST Name | Cardholder's FIRST Name | Middle

☐ Male ☐ Female ☐ Photo Copy of Insurance Card attached (optional, but preferred**)

** If possible, please enclose a copy of your insurance card when placing your first order or when changing to a different insurance.

PART C: PRESCRIPTION REFILLS (Attach prescription refill labels or fill in below)

Qty.	Prescription Number	Name of Medication	Strength of drug	Doctor's Name

IMPORTANT: To maximize savings, ask your doctor to write your prescription for 90 days supply with refills up to one year.

PART D: NEW ORIGINAL WRITTEN PRESCRIPTIONS

☐ Initial here if you are enclosing a new original prescription(s) from your doctor. Photocopies of prescriptions are not accepted.

☐ Initial here if you do not approve of generic substitutions and request for brand only on the prescriptions enclos You may have to pay the full price or a higher co-payment may apply.

☐ Initial here if you would like your maintenance /chronic medications to be enrolled into the automatic refill program. Prescriptions will be refilled when it calculates to have been ¾ utilized or per insurance limitations.

PART E: PATIENT FAMILY INFORMATION

Please complete this section accurately for each family member covered.

			Gender	Allergies	
1. Primary Cardholder's First Name	M M / D D / Y Y Y Y		M/F	No Known Allergies	See List below
2. Spouse's First Name	M M / D D / Y Y Y Y		M/F	☐	☐
3. Dependent's First Name	M M / D D / Y Y Y Y		M/F	☐	☐
4. Other Dependent's First Name	M M / D D / Y Y Y Y		M/F	☐	☐
5. Other Dependent's First Name	M M / D D / Y Y Y Y		M/F	☐	☐
6. Other Dependent's First Name	M M / D D / Y Y Y Y		M/F	☐	☐

Drug Allergies and Health Conditions

Please specify member name and list any food, drug allergies or health conditions in the box below:

PART F: PATIENT CONSENT and PAYMENT OPTIONS

Payment Options:

□. Check or Money Order □ VISA □ Master Card □ American Express □ Discover

Credit Card Number Last 4 Digits | | | | |

I certify tht the information provided on this form is correct for myself and all members covered by my health plan. I understand that generic medications will be dispensed in all cases where medically appropriate and legally permissible, unless I have stated otherwise above. In compliance with the Health Insurance Portability and Accountability Act, the information contained herein is for use only by Times Pharmacy.

SIGNATURE_____ DATE_____

Please place completed form, prescription(s), and payment in an envelope and mail to:
Times Pharmacy Mail Options c/o 1425 Liliha St, Honolulu, HI 96817
Prescriptions via mail will be received within 7 working days.

FOR OFFICE USE
USER___ DATE __/__/__

PART G: PAYMENT INFORMATION

Payment required prior to shipping. **Make check or money order payable to Times Pharmacy** (Include a valid ID# on all checks & money orders). There is a $15 fee for all returned checks.

□. Check or Money Order

□ VISA □ Master Card □ American Express □ Discover

Credit Card Number

Expiration Date
MM Y Y Y Y

		/			

Credit Card Billing Address:

Credit Cardholder's Signature:_____ Date:_____

Your credit card will automatically be billed after the prescription is processed.
If you are paying by check or money order, your medication will be mailed only after payment is received.

Times Pharmacy Mail Options
1425 Liliha Street
Honolulu, HI 96817
Toll Free Numbers - Phone: 643-6337 Fax: 643-4436