Registration and Prescription Order Form

33381 Walker Road • P.O. Box 166 • Avon Lake, OH 44012-9927
Telephone: 1-800-763-0044 • Fax: 1-800-893-2299

Please complete this form and return it along with your prescriptions in the enclosed envelope to: Immediate Pharmaceutical Service, Inc., P.O. Box 166, Avon Lake, Ohio 44012-9927. Your order will be processed within 48 hours after receipt and will be mailed via UPS or U.S. Mail.

Member Information

Male/Female:	Date of Birth:	Member ID Number *(located on card)*:
Suffix *(if on card)*:		Group Number:
Employer Name:		
Last Name:		First Name:
Daytime Telephone:		Evening Telephone:
E-mail Address *(to receive information regarding the processing of your order)*:		
Permanent Address 1		
Permanent Address 2		
City, State & Zip		

Other Dependents Eligible For Prescription Drug Program *(please print)*

Spouse	First ___	MI ___	Last ___	DOB ___	Sex ___
Dependent 1	First ___	MI ___	Last ___	DOB ___	Sex ___
Dependent 2	First ___	MI ___	Last ___	DOB ___	Sex ___
Dependent 3	First ___	MI ___	Last ___	DOB ___	Sex ___

Please Complete the Health Profile for Each Dependent

Allergies	Member	Spouse	Dependent 1	Dependent 2	Dependent 3
Aspirin	○	○	○	○	○
Cephalosporin	○	○	○	○	○
Codeine derivatives	○	○	○	○	○
Morphine derivatives	○	○	○	○	○
Penicillin	○	○	○	○	○
Sulfa drugs	○	○	○	○	○
Erythromycin	○	○	○	○	○
None known	○	○	○	○	○

Other Allergies:
Member___
Spouse___
Dependent 1___
Dependent 2___
Dependent 3___

Health Conditions	Member	Spouse	Dependent 1	Dependent 2	Dependent 3
Asthma	○	○	○	○	○
Diabetes	○	○	○	○	○
Glaucoma	○	○	○	○	○
Heart Disease	○	○	○	○	○
Hypertension	○	○	○	○	○
Thyroid Disease	○	○	○	○	○
Seizure Disorder	○	○	○	○	○
Ulcers	○	○	○	○	○
None known	○	○	○	○	○

Other Health Conditions:
Member___
Spouse___
Dependent 1___
Dependent 2___
Dependent 3___

If a dependent's medication needs to be delivered to a different address, please submit information on a separate sheet of paper or call 1-800-763-0044. ☐ I have attached additional address information

Registration and Prescription Order Form (continued)

Order Information (*Please allow 14 calendar days to receive your order)*

In an effort to provide you the greatest savings possible, Immediate Pharmaceutical Services, Inc., (IPS), substitutes FDA-approved generic equivalent drugs for brand-name drugs in all cases where legally permissible and consistent with your physician's orders and your benefit plan design guidelines. If you do not want a generic equivalent, please call our Customer Service center at 1-800-763-0044 and select the mail service option from the menu and then choose option 6; you understand that higher costs may apply.

By submitting this form, you have authorized release of all information to Catalyst Rx's mail service pharmacy, IPS, (and other necessary parties) as required to process your order under your benefit plan. Please enclose your prescription with this form. For your convenience, a refill order form and return envelope will be included with your shipment.

__________ Total number of prescriptions

__________ Total amount included for co-pay(s)

__________ Regular Shipping (no charge)

__________ Next Business Day ($42.00)

__________ 2nd Business Day ($21.00)

__________ **Total Payment Due**

Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.

Mail to: Immediate Pharmaceutical Service, Inc.
P.O. Box 166, Avon Lake, Ohio 44012-9927

Payment Option (*Payment is required at time of order. Please do not send cash.)*

☐ Check made payable to IPS

☐ Charge credit card below for this order only

☐ Place credit card below on file for this and all future orders

We accept Visa, MasterCard and Discover

Credit Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Expiration Date** ☐☐/☐☐

I authorize Catalyst Rx's mail service pharmacy, IPS, to use the credit card information provided to settle all outstanding charges incurred by myself or my policy members. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt and understand that failure to do so may result in discontinuation of pharmacy services.

Please sign below and enclose your original prescription(s).

Cardholder Signature X______________________________ **Date**__________

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