REGISTRATION / PRESCRIPTION ORDER FORM

Samaritan Pharmacy Services

MEMBER INFORMATION

Primary Cardholder Name: ______________________________
First Middle Initial Last

Address: ______________________________
Street or P.O. Box Suite or Apt # City State Zip

( ) Daytime Phone

( ) Evening Phone

Date of Birth: __ / __ / ____
MM DD YYYY

Female: ☐ Male: ☐

Doctor's Name: ______________________________
First Last

Dr.'s Phone: ______________________________

☐ Patient requests easy-off caps
☐ Patient requests Spanish language on labels

Allergies:
☐ 32-Codeine ☐ 70-Penicillin ☐ 87-Sulfa ☐ 93-Tetracycline ☐ No known allergies
☐ Other (list): ______________________________

Health Conditions:
☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma
☐ 600-Stomach Disorder ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ No known health conditions
☐ Other (list): ______________________________

EMPLOYER AND PRESCRIPTION COVERAGE INFORMATION

Prescription Benefit Provider/
Pharmacy Drug Insurance: ______________________________

Your Employer Name: ______________________________ ☐ Active ☐ Retiree

Member ID Number (from ID Card):

Group Number:

Please Note: By submitting this form, you have authorized release of all information to Samaritan Pharmacy Services (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan. Thank you for your order!
Please allow 1 week for delivery.

Please complete both pages →

REGISTRATION / PRESCRIPTION ORDER FORM, cont.

DEPENDENT INFORMATION (Print additional pages if you have coverage for multiple dependents)

Be sure to complete Member Information section

Dependent Name: ______________________________
First Middle Initial Last

Address: ______________________________
Street or P.O. Box Suite or Apt # City State Zip

( ) Daytime Phone ( ) Evening Phone

Date of Birth: __ / __ / ____ (MM DD YYYY) Female: ☐ Male: ☐

Relationship to Cardholder: ______________________________

Doctor's Name: ______________________ Dr.'s Phone: ______________
First Last

☐ Patient requests easy-off caps
☐ Patient requests Spanish language on labels

Allergies:
☐ 32-Codeine ☐ 70-Penicillin ☐ 87-Sulfa ☐ 93-Tetracycline ☐ No known allergies
☐ Other (list): ______________________________

Health Conditions:
☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma
☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ No known health conditions
☐ Other (list): ______________________________

CREDIT CARD INFORMATION

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Please circle: Visa, MasterCard, Discover)

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(American Express)

Name as it appears on card: ______________________________
First Middle Initial Last

Expiration Date: __ / __ / ____ (MM DD YYYY) Signature: ______________________

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Samaritan Pharmacy Services will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center at (541) 768-5225 to advise.

Simply mail your original prescription and this form along with your credit card information or check made payable to:

Samaritan Pharmacy Services, 3615 NW Samaritan Drive, Suite 102, Corvallis OR 97330
CustomerCare Center: (541) 768-5225, toll free 1-866-374-7245
Refills by Phone: (541) 768-5230