REGISTRATION / PRESCRIPTION ORDER FORM



SAMARITAN ADVANTAGE HMO MEMBER INFOR	RMATION
Primary Cardholder Name:	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:	Last
Dr.'s Phone:	
□ Patient requests easy-off caps□ Patient requests Spanish language on labels	
Allergies: □ 32-Codeine □ 70-Penicillin □ 87-Sulfa □ Other (list):	· · · · · · · · · · · · · · · · · · ·
Health Conditions: □ 200-Diabetes □ 300-Hypertension □ 600-Stomach Disorder □ 700-Thyroid Disease □ Other (list):	□ 800-Arthritis □ No known health conditions
EMPLOYER AND PRESCRIPTION COVERAGE INFOR	RMATION
Prescription Benefit Provider/ Pharmacy Drug Insurance:	WIATION
Your Employer Name:	ActiveRetiree
Member ID Number (from ID Card):	
Group Number:	
Please Note: By submitting this form, you have authorized release necessary parties) as required to process your prescriptions and Please allow 1	e of all information to Samaritan Pharmacy Services (and other their refills under your benefit plan. Thank you for your order! 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:
□ 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:
Expiration Date: First Middle Initial Last
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, 3521 NW Samaritan Drive, Suite 202, Corvallis OR 97330

Customer Care Center: (541) 768-5225, toll free 1-866-374-7245

Refills by Phone: (541) 768-5230