

FAX ORDER FORM

Bashas' Mail Service

PHYSICIAN: Please fax fully completed form to Bashas' Mail Service. (623)-214-6463.
TO THE PATIENT: Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Bashas' Mail Service
 15367 W. Waddell Rd.
 Surprise, AZ 85379

Customer Service (866)-902-2541 or (623)-214-6461

If you are unable to make an appointment with your doctor, follow these steps to obtain your prescription.

- Fully complete the sections below using black ink only.
 - *A credit card number is required at the time the form is submitted.*
 - Have your doctor supply the prescription information requested using prescriber's form.
 - Have your doctor fax the form to the number above.
- IMPORTANT: To be valid, the prescription must be faxed from your doctor's office.**
- Please allow 2 weeks for delivery from the date your physician faxes your prescription in.

PLEASE NOTE: By submitting this form, you have authorized release of all information to (Bashas' Mail Service and other necessary partners) as required to process your prescription and their refills under your benefit plan.

ID Number (located on ID card)		Suffix if on card 0 1	
Group Number B A S	Date of Birth / /		
Name (First, Last)	E-mail Address		
Address (please do not use P.O. Box)			
City	State	Zip Code	Daytime Phone () Evening Phone ()
PATIENT INFORMATION			
Patient Name (First, Last if different from above)		Male	Patient Date of Birth (Mo/Day/Yr)
Patient E-mail Address		Female	
PATIENT ALLERGIES		PATIENT HEALTH CONDITIONS:	
<input type="checkbox"/> No-Known	<input type="checkbox"/> 32-Codaine	<input type="checkbox"/> No Known	<input type="checkbox"/> 200-Diabetes
<input type="checkbox"/> 70-Penicillin	<input type="checkbox"/> 87-Sulfia	<input type="checkbox"/> 400-Heart Disease	<input type="checkbox"/> 500-Glaucoma
<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):	<input type="checkbox"/> 700-Thyroid Disease	<input type="checkbox"/> 800-Arthritis
Dr's Name	Dr's Phone ()	<input type="checkbox"/> 300-Hypertension	<input type="checkbox"/> 600-Stomach Disorders
PATIENT INFORMATION			

PLEASE NOTE: It is standard pharmacy practice to substitute generic equivalents for brand name drugs whenever possible. Bashas' Mail Service 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 Member Care Center to advise.

R For _____ Date _____
 Address _____ Tel _____

Facsimile Not Valid for CII prescriptions
 Valid only at Bashas' Mail Service

Dr _____ Dr _____
DISPENSE AS WRITTEN SUBSTITUTION PERMISSIBLE
MAY SUBSTITUTE

PHYSICIAN NAME _____
(PLEASE PRINT)

Refill _____ Times Address _____
 DEAF# _____ Telephone # _____

R For _____ Date _____
 Address _____ Tel _____

Facsimile Not Valid for CII prescriptions
 Valid only at Bashas' Mail Service

Dr _____ Dr _____
DISPENSE AS WRITTEN SUBSTITUTION PERMISSIBLE
MAY SUBSTITUTE

PHYSICIAN NAME _____
(PLEASE PRINT)

Refill _____ Times Address _____
 DEAF# _____ Telephone # _____