

**TEAMSTER RETIREE - MEDICARE PART D
MAIL ORDER PRESCRIPTION ORDER FORM - COMMUNITY CARE RX GOLD PLAN**

PATIENT NAME		PATIENT ID #		PATIENT DATE OF BIRTH	
SHIPPING ADDRESS <input type="checkbox"/> NEW ADDRESS			EMAIL ADDRESS		
CITY, STATE, ZIP CODE			DAYTIME PHONE		
LIST ANY CHRONIC MEDICAL CONDITIONS		LIST ANY DRUG ALLERGIES		EVENING PHONE	
				VISA OR MASTERCARD No. EXP. DATE	
				TRANSFER PHARMACY NAME & PHONE (IF APPLICABLE)	

**NOTE: FOR NEW PRESCRIPTIONS, SIMPLY ENCLOSE THE PAPER PRESCRIPTION. FOR REFILLS, PLEASE FILL OUT ONE LINE BELOW FOR EACH PRESCRIPTION. YOU MAY REQUEST UP TO A 90 DAY SUPPLY
CO-PAYMENTS FOR THE CCRX GOLD PLAN ARE AS FOLLOWS: GENERICS - \$4/MONTH ~ PREFERRED BRANDS - \$25/MONTH ~ FORMULARY BRANDS - \$50/MONTH**

RX NUMBER	NAME OF DRUG	STRENGTH	GENERIC OK?	QUANTITY	DAYS SUPPLY	PRESCRIBING PRACTITIONER

I CERTIFY THE INFORMATION GIVEN HERE IS CORRECT AND AUTHORIZE MY PHARMACY TO FILL THE ENCLOSED AND/OR LISTED PRESCRIPTIONS.

PATIENT'S SIGNATURE _____

DATE _____

CHILD RESISTANT CAP? YES
PLEASE INITIAL NO