



Mail Order Form

Please complete the following information for each prescription you are requesting:

Name of Patient on the Prescription	Date of Birth	Name of Insurance	Member ID	If Ordering Refills, List Rx Numbers

Please list drug allergies: _____

PLEASE ALLOW SEVEN TO TEN DAYS FOR FULFILLMENT AND DELIVERY

SHIPPING ADDRESS: (A signature is required for delivery)

Name

Street

City

State

Zip

Daytime Phone

- Standard shipping is free
- Express shipping is available at additional cost
- Requests may be made by phone, fax, or mail
- Please complete all fields on form to avoid delays in processing

PAYMENT OPTIONS:

- MasterCard Visa Discover
- Please use this credit card information for future transactions
- Check (*payable to Methodist Retail Pharmacy*)
- Money order enclosed

Credit Card Number

Exp. Date

Name
(as it appears on card)

Signature

Please return the completed form with original written prescription and payment to:

MAIL ORDER CUSTOMER SERVICE
Methodist Retail Pharmacy
1801 North Senate Blvd, Room 105
Indianapolis, IN 46202
Fax: (317) 963-0525

Questions? Please contact our pharmacy staff at (317) 963-0515 or toll-free at 800-467-7979 for further assistance.