



# Blue Cross and Blue Shield of Texas Mail Order Form — PrimeMail™ Pharmacy

## PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using black ink only.

For **NEW** prescriptions you may use either:

- **MAIL** — Mail the original physician-signed prescriptions with this completed form to: **Blue Cross and Blue Shield of Texas**  
c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041
- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to **877.774.6360** provided you have either previously completed and submitted this form or registered at **www.bcbstx.com**

For **REFILL** prescriptions you may use:

- **PHONE** — Call our automated refill line at 877.357.7463.
- **WEB** — Visit **www.bcbstx.com**
- **MAIL** — Mail this form with the refill information completed to:  
**Blue Cross and Blue Shield of Texas**  
c/o PrimeMail Pharmacy P.O. Box 650041, Dallas, TX 75265-0041

Prescription Member Spouse Dependent	Patient Name	Physician Name/Phone Number/Drug Name (for new prescriptions only)	Prescription Numbers (for refills only)						
1									
2									
3									
4									
5									
6									

PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.

## PAYMENT SECTION — Payment is due with each order and may be made by credit card, check or money order.

**Do not send cash.** Orders received without payment will delay processing. Credit card is the only payment option for faxed orders. If you have questions about your payment amount, call the Prescription Drug Inquiry Unit at **877.299.2377** for HMO Blue Texas members or **800.521.2227** for all other members.

**Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

Check Amount: \_\_\_\_\_ Check Number: \_\_\_\_\_

**Payment by credit card** (Provide information below)  MasterCard  Visa  American Express  Discover

**Use credit card on file, with the last four digits:**

**Use alternate credit card number** \_\_\_\_\_ Expiration Date (MM/YYYY) \_\_\_\_\_

**Use this card for all future orders**

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

Credit card holder's signature

## SHIPMENT SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

**Regular** — no charge  **Second Business Day\***  **Next Business Day\*** \*Additional costs charged to you

If you've chosen Second Business Day or Next Business Day shipping, we are unable to ship to P.O. boxes. Shipping address must be a physical location.

**Ship to Permanent Address**

**Spanish prescription labels**

Alternate Shipping Address (If different than permanent address)

City State Zip Code Phone Number

Above address is:  For this order only  For this and all future orders

All medications in this order will be sent to the address provided on this form. If a family member's medication needs to be delivered to a separate address, please submit a separate order form.

By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

† A division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association