



Registration and Prescription Order Form

33381 Walker Road • P.O. Box 166 • Avon Lake, OH 44012-9927
Telephone: 1-800-763-0044 • Fax: 1-800-893-2299

Please complete this form and return it along with your prescriptions in the enclosed envelope to: Immediate Pharmaceutical Services, Inc., P.O. Box 166, Avon Lake, Ohio 44012-9927. Your order will be processed within 48 hours after receipt and will be mailed via UPS or U.S. Mail.

Member Information

Male/Female:	Date of Birth:	Member ID Number (located on card):
Suffix (if on card):	Group Number:	
Employer Name:		
Last Name:		First Name:
Daytime Telephone:		Evening Telephone:
E-mail Address (to receive information regarding the processing of your order):		
Permanent Address 1		
Permanent Address 2		
City, State & Zip		

Other Dependents Eligible For Prescription Drug Program (please print)

Spouse	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 1	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 2	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 3	First _____	MI _____	Last _____	DOB _____	Sex _____

Please Complete the Health Profile for Each Dependent

Allergies	Member	Spouse	Dependent 1	Dependent 2	Dependent 3	Health Conditions	Member	Spouse	Dependent 1	Dependent 2	Dependent 3
Aspirin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cephalosporin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Codeine derivatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Morphine derivatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Penicillin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sulfa drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Erythromycin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Seizure Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None known	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
						None known	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Allergies:						Other Health Conditions:					
Member _____						Member _____					
Spouse _____						Spouse _____					
Dependent 1 _____						Dependent 1 _____					
Dependent 2 _____						Dependent 2 _____					
Dependent 3 _____						Dependent 3 _____					

If a dependent's medication needs to be delivered to a different address, please submit information on a separate sheet of paper or call 1-800-763-0044. I have attached additional address information

