Print form, fill out completely & mail to:
Prescription Mart, PO Box 12607, Beaumont, TX 77726

Mail In - Prescription Request Form

Email

Employee Name

Day Phone

Address

City State Zip

CERTIFICATION STATEMENT

IMPORTANT:I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, sponsor, policyholder and employer. I have read the CERTIFICATION STATEMENT and hereby certify to and accept the terms thereof.

Employee's Cardholder Id #

Employee's Signature

Date

Number of Rx's enclosed

Amount of co-payment enclosed
$

Prescription Mart Refills

If you are ordering authorized refills of prescriptions that you already have with us, list the Rx numbers and medication names from your labels here:

Patient Name	Rx #	Medication

New Prescriptions

If you are enclosing prescriptions with this form, we must have the patient name AND date of birth for all prescriptions. Patients that are new with Prescription Mart must also submit a Patient Profile form.

Patient Name	Date of Birth

Payment Information

☐ Check enclosed
☐ Please charge my credit card

☐ Visa or ☐ MasterCard ☐ Discover

Bank card No.

Exp. Date

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