Step 1: Print form, fill out completely & mail to:
Prescription Mart, PO Box 12607, Beaumont, TX 77726

PATIENT PROFILE FORM

Male ☐ Female ☐

Employer | Group#

Employee Name

Phone Number | Date of Birth

Address

City | State | Zip

Family Doctor's Name | Dr.'s Phone Number

Does the employee have allergies?
Yes ☐ No ☐ If yes, please describe:

Chronic disease?
Yes ☐ No ☐ If yes, please describe:

Sensitivity to drugs?
Yes ☐ No ☐ If yes, please describe:

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

List all eligible dependents below:
If an eligible dependent in your family has any allergies, chronic diseases, or is sensitive to any drugs, list below.
If you have no eligible dependents, check this box. ☐

Patient's Name | Relationship | DOB
Sex | Allergy/Sensitivity | Dr.'s Name

Patient's Name | Relationship | DOB
Sex | Allergy/Sensitivity | Dr.'s Name

Patient's Name | Relationship | DOB
Sex | Allergy/Sensitivity | Dr.'s Name

Patient's Name | Relationship | DOB
Sex | Allergy/Sensitivity | Dr.'s Name

Prescription Request Form

Number of Rx's enclosed | Amount of co-payment enclosed $

The prescriptions enclosed are for: (Fill in name and date of birth for dependents.)

☐ Employee

☐ Spouse

☐ Son
Date of Birth ☐ Student

☐ Daughter
Date of Birth ☐ Student

☐ Check enclosed ☐ Please charge my credit card

☐ Visa or ☐ MasterCard ☐ Discover Bank card No.

Exp. Date