

Convenience

- > After you enroll in our service, your doctor easily can send new prescription orders for you by phone, mail, fax, or ePrescribe. When the mail order pharmacy gets a prescription directly from your doctor, you will be called first to confirm that you want the drug(s).
- > Our pharmacy team members will contact you for refill reminders.
- > You can receive up to a 90-day supply of drugs.
- For any questions or concerns about your drugs, you can speak to one of our pharmacists by phone or email at Homescripts.com.



Customer Service Center

Toll-free: 1-888-239-7690



Hours of Operation

Weekdays: 8 a.m. – 8 p.m. EST Saturday: 10 a.m. – 2 p.m. EST



Mailing Address

500 Kirts Blvd., Suite 300 Troy, MI 48084 Homescripts is a mail order pharmacy that offers prescription drugs sent safely to your home. If you have one or more prescriptions for maintenance or long-term conditions like high blood pressure, arthritis, diabetes, or depression, our mail service may be right for you. Our high quality and nocost delivery make it easy to get your maintenance drugs through the mail. Homescripts also helps reduce trips to your retail pharmacy.

Packaged for Safety

Our pharmacists process all mail service prescriptions and mail your drugs in plain, tamper-proof packages. Refrigerated drugs arrive in a temperature-safe package.

Enroll Today

Complete enrollment using one of the options below:



OPTION 1

Email. Send completed form to customerservice@homescripts.com.



OPTION 2

Phone. Call to enroll at 1-888-239-7690.



OPTION 3

Mail. Mail your completed enrollment form to Homescripts.

Easy Refills

You can refill your prescriptions in three simple ways:



OPTION 1

Online. Log into Homescripts.com.



OPTION 2

Phone. Call us at 1-888-239-7690. You can leave a message without having to wait to speak with someone.



OPTION 3

Mail. Mail your completed consent form that comes with every package.

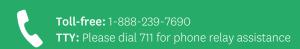
Phone: 888.239.7690

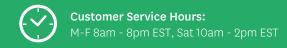




Member Enrollment Form

STEP 1 - PERSONAL INFORMATION			
Name:	Date of Birth (mm/dd/yy):		
Address:	City: State:		
Zip Code: Home Ph	one: Mobile Phone:		
Email Address:*			
Emergency Contact:	Phone:		
Relationship to Member:			
Allergies: ☐ None ☐ Aspirin ☐ Co	deine 🗆 Iodine 🗆 Penicillin 🗆 Sulfa Other:		
Health Condition(s): ☐ Thyroid ☐ ☐	iabetes Arthritis Heart Conditions High Blood Pressure		
☐ Asthma ☐ High Cholesterol Oth	er:		
3 / 3	email notifications regarding your prescription benefits, as well as other information on behalf of Homescrip il service at any time by contacting us or following the opt-out instructions included in each email you receiv		
STEP 2	- HEALTHCARE PRACTITIONER INFORMATION		
Name (Printed):	Phone Number:		
Office Location:			
STEP 3	- PRESCRIPTION INSURANCE INFORMATION		
Policyholder (if different than above):			
Relationship to Member:			
Cardholder ID #:	Rx Group:		
Rx BIN #:	PCN/Plan Code:		
Insurance Name:	Insurance Phone Number:		
	STEP 4 - PAYMENT INFORMATION		
Credit Card Type: ☐ Visa ☐ Masterd	card □ Discover □ Amex Use this card for future orders? □ Yes	□ No	
Credit Card #:	Expiration Date:/ Is this an FSA card? \square Yes		
Cardholder Name:	Cardholder Signature:		
FRM015294E000	(turn over to complete)	DORO11	









Member Enrollment Form

STEP 5 - MEDICATION HISTORY

Please list all prescription and over the counter medications you are currently taking.

Medication Name	Strength

Medication Name	Strength

STEP 6 - NEW PRESCRIPTION(S) INFORMATION



OR

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Send Prescriptions by Mail to:

Homescripts Pharmacy Attn: New Member Enrollment 500 Kirts Blvd., Suite 300 Troy, MI 48084

Ask Your Provider to Call or Fax Prescriptions to:

Homescripts Pharmacy
Attn: New Member Enrollment
500 Kirts Blvd., Suite 300 | Troy, MI 48084
Phone: (888) 239-7690 | TTY: Please dial 711 **OR**

Fax to: (877) 396-5970

Law prohibits **patients** from emailing or faxing prescriptions directly to the pharmacy.

STEP 7 - SPECIAL INSTRUCTIONS

Please include any special instructions regarding your order:

STEP 8 - PLEASE READ, SIGN & DATE

I certify that the information provided on this form is correct and authorize the release of all information to Homescripts, I authorize my provider to send my prescription(s) to Homescripts, I authorize my provider to consult with a Homescripts pharmacist regarding any medication related concerns, and I AUTHORIZE HOMESCRIPTS PHARMACY TO SUBSTITUTE ANY FDA APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PROVIDER'S ORDERS AND MY BENEFIT PLAN.

Printed Name:	
Signature of Member of Legal Representative:	Date:
☐ Yes, I would like to receive easy-open, non-safety caps. Initials	Please email the completed, saved form to



