

REGISTRATION / PRESCRIPTION ORDER FORM



SAMARITAN SELECT MEMBER INFORMATION

Primary Cardholder Name: _____
First Middle Initial Last

Address: _____
Street or P.O. Box Suite or Apt # City State Zip

(____) _____
Daytime Phone

(____) _____
Evening Phone

Date of Birth: ____/____/____
MM DD YYYY

Female: Male:

Doctor's Name: _____
First Last

Dr.'s Phone: _____

- Patient requests easy-off caps
- Patient requests Spanish language on labels

Allergies:

- 32-Codeine 70-Penicillin 87-Sulfa 93-Tetracycline No known allergies
- Other (list): _____

Health Conditions:

- 200-Diabetes 300-Hypertension 400-Heart Disease 500-Glaucoma
- 600-Stomach Disorder 700-Thyroid Disease 800-Arthritis No known health conditions
- Other (list): _____

EMPLOYER AND PRESCRIPTION COVERAGE INFORMATION

Prescription Benefit Provider/
Pharmacy Drug Insurance: _____

Your Employer Name: _____ Active Retiree

Member ID Number (from ID Card):

Group Number:

Please Note: By submitting this form, you have authorized release of all information to Samaritan Pharmacy Services (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan. Thank you for your order!
Please allow 1 week for delivery.

Please complete both pages ➡➡

REGISTRATION / PRESCRIPTION ORDER FORM, cont.



DEPENDENT INFORMATION (Print additional pages if you have coverage for multiple dependents)

Be sure to complete Member Information section

Dependent Name: _____
First Middle Initial Last

Address: _____
Street or P.O. Box Suite or Apt # City State Zip

() ()
Daytime Phone Evening Phone

Date of Birth: / / Female: Male:
MM DD YYYY

Relationship to Cardholder: _____

Doctor's Name: _____ Dr.'s Phone: _____
First Last

Patient requests easy-off caps
 Patient requests Spanish language on labels

Allergies:
 32-Codeine 70-Penicillin 87-Sulfa 93-Tetracycline No known allergies
 Other (list): _____

Health Conditions:
 200-Diabetes 300-Hypertension 400-Heart Disease 500-Glaucoma
 600-Stomach Disorders 700-Thyroid Disease 800-Arthritis No known health conditions
 Other (list): _____

CREDIT CARD INFORMATION

Credit Card Number: _____
(Please circle: Visa, MasterCard, Discover)

Credit Card Number: _____
(American Express)

Name as it appears on card: _____
First Middle Initial Last

Expiration Date: / / Signature: _____
MM DD YYYY

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Samaritan Pharmacy Services will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center at (541) 768-5225 to advise.

Simply mail your original prescription and this form along with your credit card information or check made payable to:
Samaritan Pharmacy Services, 3615 NW Samaritan Drive, Suite 102, Corvallis OR 97330
CustomerCare Center: (541) 768-5225, toll free 1-866-374-7245
Refills by Phone: (541) 768-5230