Order Form for New Prescriptions and Refills

Information

Identification Number | Plan Name | Plan Number (if known)

Last Name | First Name | Initial

Ship to This Address

☐ Please check here if this is a change of address.

Street Address (no P.O. Boxes please) | Apt. or Suite | City

State | Zip Code | Home Phone Number | Work Phone Number

Patient Information

Last Name | First Name | Initial

Birthday | Sex ☐ Male ☐ Female ☐ Please, no child-proof caps

Physician Information

Last Name | First Name | Initial | Physician's Phone Number

☐ **Check here if you DO NOT wish to use a generic product.**

If you check the above box, you may be required to pay a higher co-payment or your medication may not be covered by your prescription plan, depending on your plan. Refer to your benefit materials for details.

Drug Allergies

☐ Aspirin ☐ Penicillin
☐ Codeine ☐ None
☐ Sulfonamides ☐ Other _____

For refills: Write the prescription number from Avera Specialty Pharmacy below or call 605-322-8300 or 855-442-8372 (see back for contact information), 14 – 21 days before running out of your current prescription.

RX No._____ RX No._____
RX No._____ RX No._____
RX No._____ RX No._____

Health Conditions (to monitor drug/disease interactions)

☐ Arthritis ☐ High blood pressure
☐ Diabetes ☐ Intestinal disorders
☐ Glaucoma ☐ Lung condition
☐ Heart condition ☐ Thyroid
☐ Other _____

Would you like to receive a call from a pharmacist to counsel you on your medications or to discuss your medications with you? ☐ Yes ☐ No

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 and authorize the release of all information to the plan administrator. I certify that I do not have primary prescription coverage under another plan. If the prescription coverage is denied, I agree to reimburse the Avera Specialty Pharmacy, for the amount of benefit which is being denied under the prescription plan.

Insured's signature _____ Date _____

Method of Payment (if applicable)

☐ Check ☐ Money Order or Cashier's Check
☐ MasterCard ☐ Visa ☐ Discover
Credit Card Number_____ Expiration Date_____
Name as it appears on card _____
Billing address on credit card _____

Prescription Enclosed

Quantity of New Prescriptions _____
Quantity of Refill Prescriptions _____
Total Quantity (new + refill) _____
Co-payment Amount Enclosed $_____

I understand all co-payments and/or prescription costs for products purchased through the Specialty Pharmacy will be charged to the credit card provided above. I understand signing this form means prescription medications cannot be returned to the pharmacy for credit unless in response to a recall, defect in a medical device, or otherwise pre-approved by the pharmacy. I understand returned medication, for any reason, will be destroyed and will not be available for credit. I acknowledge the credit card information provided above is for a credit card, not a debit/check card.

Signature of cardholder_____ Date _____

Avera Specialty Pharmacy • 1301 S. Cliff Ave,, Suite 200 • Sioux Falls, SD 57105
605-322-8300 or 855-442-8372 • Fax: 605-322-8361

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Customer Care team at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
Avera Health Plans
5300 S Broadband Ln
Sioux Falls, SD 57108-2221

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Avera Health Plans

Getting Help in Other Languages

Language assistance services are available free of charge. Our Customer Care team is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-325-2115 (رقم هاتف الصم والبكم: 1-800-877-1113).
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (ATS: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: TTY: 1-800-877-1113).
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-888-322-2115 (TTY: 1-800-877-1113).