301 Main Street
Stevensville, MT 59870
Phone: 406-777-5591
Toll Free: 800-870-5591
Fax: 406-777-5150
pharmacy@familypharmacist.com
www.familypharmacist.com

GET BOTH 90-DAY PRESCRIPTION SAVINGS AND IN-STATE SERVICE

Valley Drug & Variety pharmacy offers delivery by mail service, exceptional customer service, and is based in Montana's oldest community. If you have any questions about your prescription service pharmacy benefits, please call Valley Drug & Variety at **1-800-870-5591, FAX: 1-406-777-5451**.

Here's how the delivery by mail program benefits you:

QUALITY – Our prescription service with delivery by mail delivery is the same as our walk-up service. Every prescription is carefully checked by our pharmacists.

CONVENIENCE – With Valley Drug & Variety's delivery by mail program, you receive fast, convenient delivery of maintenance medications directly to your home.

SAVINGS – You get the savings of 90-day prescriptions, but still keep your dollars in state.

Please see the other side for instructions on how to use our delivery by mail service.

Member ID # ______ Company Name ______

Last Name ______ First Name ______ Middle Initial ______ Sex ______

Mailing Address ______ Apt or Suite # ______

City ______ State ______ Zip ______

Birth date (mo/day/yr) ______ ( ) Daytime Phone # ______ ( ) Evening Phone # ______

Method of Payment: (you may change payment method at any time)

☐ Check (payable to Valley Drug)

☐ Visa ☐ MasterCard ☐ Discover Card

☐ American Express ☐ Money Order/ Cashier's check

Credit Card Number: ______ Expiration Date: ______

Your signature confirms your receipt of Valley Drug & Variety's patient information packet, receipt of HIPAA privacy information, assignment of benefits to your insurance company, and authorization to bill your credit card (if provided) for prescription services.

Member Signature **(Required)** ______ Date ______

Check One:

☐ Employee ☐ Medicare Part B

☐ Retiree ☐ Cobra

Physician Information:

Physician Name & Phone # ______

Check all that apply:

Health Conditions	**Drug Allergies**
☐ Asthma (493.90)	☐ None
☐ Arthritis (714.00)	☐ Aspirin (03)
☐ Diabetes (250.01)	☐ Codeine (04)
☐ Depression (311.00)	☐ Erythromycin (09)
☐ Glaucoma (365.90)	☐ Iodine (29)
☐ High Cholesterol (272.0)	☐ Penicillin (01)
☐ Hypertension (402.90)	☐ Sulfa (15)
☐ Low Thyroid (244.9)	
☐ High Thyroid (242.9)	
☐ Other Thyroid (245.90)	

Other health conditions or drug allergies:

______

I prefer "easy open" caps: ☐ Yes ☐ No

For new mail service prescriptions, please follow these simple steps:

1. If you need to start your medication right away, have your physician complete two prescriptions. Please be sure the prescription from your physician is legible, includes the drug's name, strength, and quantity to dispense, the exact daily dosage, the physician's name, phone number, and DEA number.
2. Fill one prescription immediately at a pharmacy and submit the other prescription to Valley Drug and Variety for a supply determined by your pharmacy benefit plan. Encourage your physician to write your prescription for the maximum number of days covered by your pharmacy benefit plan. This will help you to maximize your benefit and save money.
3. Complete this patient profile form. Please be sure to write your participant ID number in the space provided on the profile. Your ID number is generally your social security number. If your benefit plan includes dependent coverage, please fill out the dependent section(s), even if you are not ordering medications for them at this time. If more space is required for dependents, please list them on a separate sheet.
4. Mail this patient profile form, the original prescription(s) and co-payment, if applicable, to Valley Drug & Variety. If your plan requires a co-payment, please provide your credit card information on the patient profile. You can expect delivery of your order within 14 days from the date your order is postmarked.

Please note: A complete street address is required for controlled substance medications, and an adult signature is required upon receipt. To realize cost savings, we will dispense FDA approved generic medications, when allowed by your physician, subject to the terms outlined in your prescription benefit plan design. **Please remember to call in your refill numbers at least 2 weeks before you run out of medication.**

Dependent #1 Last Name First Name Middle Initial

Birth date (mo/day/yr) Sex

Physician Information:

Physician Name & Phone #

Other health conditions or drug allergies:

Your signature confirms receipt of Valley Drug & Variety's patient information packet and HIPAA privacy information, and assignment of benefits to your insurance company.

Dependent/Guardian Signature **Required** Date

Check One:

☐ Spouse ☐ Child

Check all that apply:

Health Conditions	**Drug Allergies**
☐ Asthma (493.90)	☐ None
☐ Arthritis (714.00	☐ Aspirin (03)
☐ Diabetes (250.01)	☐ Codeine (04)
☐ Depression (311.00)	☐ Erythromycin (09)
☐ Glaucoma (365.90)	☐ Iodine (29)
☐ High Cholesterol (272.0)	☐ Penicillin (01)
☐ Hypertension (402.90)	☐ Sulfa (15)
☐ Low Thyroid (244.9)	
☐ High Thyroid (242.9)	
☐ Other Thyroid (245.90)	

Dependent #2 Last Name First Name Middle Initial

Birth date (mo/day/yr) Sex

Physician Information:

Physician Name & Phone #

Other health conditions or drug allergies:

Your signature confirms receipt of Valley Drug & Variety's patient information packet and HIPAA privacy information, and assignment of benefits to your insurance company.

Dependent/Guardian Signature **Required** Date

Check One:

☐ Spouse ☐ Child

Check all that apply:

Health Conditions	**Drug Allergies**
☐ Asthma (493.90)	☐ None
☐ Arthritis (714.00	☐ Aspirin (03)
☐ Diabetes (250.01)	☐ Codeine (04)
☐ Depression (311.00)	☐ Erythromycin (09)
☐ Glaucoma (365.90)	☐ Iodine (29)
☐ High Cholesterol (272.0)	☐ Penicillin (01)
☐ Hypertension (402.90)	☐ Sulfa (15)
☐ Low Thyroid (244.9)	
☐ High Thyroid (242.9)	
☐ Other Thyroid (245.90)	

Dependent #3 Last Name First Name Middle Initial

Birth date (mo/day/yr) Sex

Physician Information:

Physician Name & Phone #

Other health conditions or drug allergies:

Your signature confirms receipt of Valley Drug & Variety's patient information packet and HIPAA privacy information, and assignment of benefits to your insurance company.

Dependent/Guardian Signature **Required** Date

Check One:

☐ Spouse ☐ Child

Check all that apply:

Health Conditions	**Drug Allergies**
☐ Asthma (493.90)	☐ None
☐ Arthritis (714.00	☐ Aspirin (03)
☐ Diabetes (250.01)	☐ Codeine (04)
☐ Depression (311.00)	☐ Erythromycin (09)
☐ Glaucoma (365.90)	☐ Iodine (29)
☐ High Cholesterol (272.0)	☐ Penicillin (01)
☐ Hypertension (402.90)	☐ Sulfa (15)
☐ Low Thyroid (244.9)	
☐ High Thyroid (242.9)	
☐ Other Thyroid (245.90)	