Instructions: Complete this form and mail it with the required physician prescription(s) to:

Clearscript Prescription Mail Service
Fairview Mail Service Pharmacy
3650 Victoria St. N., Shoreview, MN 55126

Please select from the following:

☐ New prescription(s) - Place on my medication profile. I will contact Fairview Mail Service when I want my prescription(s) filled.
☐ New prescription(s) - Dispense and mail out when received
☐ Updating demographic information

PLEASE PRINT

Refer to your employee benefits information for copay amounts. Enclose your original prescription(s) and your credit card payment information.

Patient Demographics

Patient Name: Date of Birth: Male/Female:

Address:

City: State: Zip Code:

Home Phone: Work Phone: Mobile Phone:

Parent/Guardian Name (if applicable):

Physician Name: Office Phone Number:

Allergies:

☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Erythromycin ☐ Sulfa ☐ Penicillin ☐ Other _____

Health Conditions:

☐ Asthma ☐ Diabetes ☐ Glaucoma ☐ High Cholesterol ☐ Arthritis ☐ High Blood Pressure

☐ Thyroid (low) ☐ Thyroid (high) ☐ Other _____

Prescriptions & over-the-counter medications currently taking:

Insurance Information

Insurance Name: ID Number:

Group: BIN: PCN:

Payment Information

☐ **Charge to my credit card below** ☐ **Pharmacy to call me for payment information**

Cardholder Name: Account Number:

Cardholder Signature: Expiration Date:

☐ Mastercard ☐ Visa ☐ American Express ☐ Discover

Shipping Information (if different from above)

Name:

Address: City State/Zip:

I certify that all information on this form is correct. I permit Fairview Mail Service Pharmacy to release all information to plan sponsor, administrator or underwriter.

X

Signature Required

Easy-Open Containers

Please sign below if you want prescriptions dispensed in containers that are NOT child-resistant.

X

Signature Required

SW544950 Rev 10/25

Fairview Mail Service Pharmacy
1-866-377-6245
www.fairview.org/mailservice

Fairview

FIIRO GAAR AH: **Hadii aad ku adasho Soomaali, waaxda luqadaha, qaybta kaalmada adeegyada, waxay idiin hayaan adeeg kharash la'aan ah. So wac 612-273-3780.**

ATENCIÓN: **Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-273-3780.**

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 612-273-3780。

We comply with applicable federal civil rights laws and Minnesota laws. We do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.