**Frequently Asked Questions**

**How do I start filling prescriptions with DrugSource?**

Complete this patient profile form and mail it in with your maintenance prescription(s) written for a 90-day supply

OR

Log onto www.drugsourcemin.com to complete the online patient profile form. You can either mail in the paper version of your prescription(s) or fill out a request for us to fax your physician

(*Note: Some physicians may require you to mail in the written prescription. Please check with your doctor’s office.)

**What is the turn-around time for my prescriptions?**

Please allow 10 to 14 business days to receive your order. (This time may vary).

**How can I refill my prescriptions?**

Complete the section 3 of this form and mail it in

OR

Log onto www.drugsourcemin.com and click “Refill Order / Status” (have the DrugSource prescription number and Date of Birth of the patient handy)

OR

Call 800/854-8764 to speak to our customer service team or use our automated touch-tone refill line

OR

Fax in your refills to 847/258-1913

**What if my prescription is out of refills?**

Call our customer service team and we can contact your physician

OR

Log onto www.drugsourcemin.com. Click Refill Order / Status. Click on View Medication History and click the prescription you would like to refill. If the prescription is expired/needs refills, we will contact your physician.

OR

Mail in another written prescription with the patient’s name and Date of Birth printed on its back

OR

Have the doctor fax in a prescription to 847/258-1913

(Prescriptions may ONLY be faxed by the physician’s office)

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**Patient Profile Form**

**Primary Plan Member Information**

Please fill in all areas with the required information.

Your ID number, Group number and Bin number can be found on your health plan card.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>UCSHIP</th>
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</thead>
<tbody>
<tr>
<td>I.D. Number</td>
<td>Group Number</td>
</tr>
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</table>

Primary Plan Member’s Name (Please Print) ____________________________________________

Address

Phone (

Daytime (____

Shipping Address, if different ______________________________________________________

Cardholder’s Date of Birth ____ / ____ / _______ O Male O Female Are you pregnant at this time? O Yes O No

Describe Cardholder’s drug allergies/medical conditions: Check here if none: O

List Prescription (RX)/OTC Medications you are currently taking (including RXs DrugSource has not filled):

Attach additional paper, if necessary.

Print Name of Physician ordering medications ______________________________________

Physician Phone Number (____) ________________________________

Physician Fax (____) ________________________________

O Please send me an email notice when my package is shipped. O Please correspond with me about orders through this email.

EMAIL ADDRESS ________________________________________________________________

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**Dependent Information**

If you have no eligible dependents, check here -- O

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<thead>
<tr>
<th>Name</th>
<th>O Spouse O Dependent</th>
<th>O Male O Female</th>
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<tbody>
<tr>
<td>Date of Birth ____ / ____ / ______</td>
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<tr>
<td>Drug Allergies / Medical Condition</td>
<td>Doctor’s Name</td>
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List RXs/OTC Meds Currently Taking:

<table>
<thead>
<tr>
<th>Name</th>
<th>O Spouse O Dependent</th>
<th>O Male O Female</th>
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List RXs/OTC Meds Currently Taking:
### Refill Information

This section is for prescriptions you have filled with DrugSource in previous orders.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB / /</th>
<th>Rx#</th>
<th>Med</th>
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**Remember:** You can log onto [www.drugsourceinc.com](http://www.drugsourceinc.com) or call our automated refill line (800) 854-8764 for easy access to refill your medications.

### Contact Physician/Transfer Information

Fill out the section below if you would like us to contact your physician or your previous pharmacy* for prescriptions.

<table>
<thead>
<tr>
<th>Medication Name/Rx #</th>
<th>Strength / Quantity / Prescription Directions</th>
<th>Doctor Information</th>
<th>Fill Now</th>
<th>Fill Later</th>
<th>Patient Name</th>
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*Note: We will need your previous prescription numbers from your pharmacy to transfer. If there are no refills, we will contact your doctor.

### Payment Information

Check the box to choose the type of payment you would like to use for your order.

- **Electronic Check.** Include a voided check or its copy.
- **Check/Money Order Enclosed** Check# _______
  
- **Credit/Debit/FSA Card**
  - **Use Credit Card on file**
  - **This is a New Credit Card**
    - **Keep On File**
    - **One Time Use**

**Please contact us if you have any questions about how much you should enclose/what your co-pay is.**

($20 returned check service charge will apply)

**Amount of Co-payment $ ____________**

**We care about the needs of our customers. That’s why we offer home delivery of every product we sell.**