Order Form (please print)

Patient Name (First MI Last)		Date of Birth
Shipping Address*		
City	State	Zip
Preferred Phone Number	Alternate Phone Number	
Member ID #	Group #	

* A physical address (not a P.O. Box) is typically required for temperature-sensitive medications and controlled substances.

Shipping Methods: ☐ Normal (no charge) ☐ 2nd Day Air ($11.00) ☐ Next Day Air ($25.00)

Payment Methods:

- ☐ Check
- ☐ Money Order
- ☐ Visa
- ☐ MasterCard
- ☐ American Express
- ☐ Discover

Credit Card Payments choose one:

- ☐ One-time use only
- ☐ Approved for future recurring orders

Credit Card #: _____

Exp. Date: _____

_____
Name of Cardholder

NOTE: Make check payable to: Catamaran Home Delivery. DO NOT send cash. Orders received without payment may result in delays in processing and may therefore extend delivery times.

I certify the information provided on this form is correct. I authorize the release of all information to the plan sponsor, administrator or underwriter. I authorize Catamaran to substitute generic drugs in all cases where permissible under applicable state laws and consistent with doctor's orders. My signature also acknowledges I have been provided with a copy of the Notice of Privacy Practice.

_____
Signature

_____
Date

Total Co-Payment: $ _____

Shipping: $ _____

Total: $ _____

State and federal regulations require patient identification when dispensing controlled substance prescriptions. Please provide **one** of the following:

Driver's License:
State _____ #_____

— *or* —

Social Security #_____

Contact Us

Catamaran Home Delivery
P.O. Box 166
Avon Lake, OH 44012-9927

Member Services
Phone: 1.800.763.0044 (TTY: 888.206.8041)
Fax: 1.800.893.2299
Monday-Friday 8am-10pm (EST)
Saturday 8am-5pm (EST)
Sunday Closed

www.mycatamaranRx.com

Catamaran™ Home **Delivery** for prescription medications

the convenient and cost-effective way to get your prescriptions filled

catamaran™
stay well ahead

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209-083012-1

Getting Started

Have your doctor write your prescription for the maximum days supply allowed by your plan (typically a 90-day supply plus 3 refills for a one-year supply).

Write the patient's name, date of birth and identification number on the back of each original prescription.

Complete the order form and patient profile section of this brochure. Mail the form, original prescriptions and payment information to:

Catamaran Home Delivery
P.O. Box 166
Avon Lake, OH 44012-9927

We'll do the rest!

Most orders are shipped through the U.S. Postal Service with delivery to your home, office or alternate location. Controlled substances may require an adult signature upon receipt. Packaging does not indicate that medications are enclosed.

Please allow 10–14 days for delivery of your prescriptions. Expedited shipping options are also available. Please note that this only reduces transit time and will NOT affect the processing time of your prescription. If you do not get your order within 14 days, please contact Member Services.

for additional information

call 1.800.763.0044
(TTY: 888.206.8041)
or visit mycatamaranRx.com

Frequently Asked Questions

What drugs are covered?

Prescription drugs that are covered by your benefit plan are available through mail order. Insulin, insulin syringes and test strips need a prescription when you order them through Catamaran Home Delivery.

When will I get my order?

You should receive your order within 10–14 days. Please allow a few extra days for your first order.

Am I charged for shipping?

Shipping is free. You can get Next Day or Second Day delivery for an extra charge.

Is my information kept private?

Yes, we keep this information completely private. Please read the Notice of Privacy Practices included with this guide. After reading it, you must sign the bottom of the order form.

Patient Profile

Use one form per patient.
Additional forms are available at mycatamaranRx.com.

Please review your order carefully. Once submitted, an order cannot be cancelled or returned.

	Drug Allergies						Medical Conditions					
	Other	Penicillin	Codeine	Sulfa	Aspirin	None	Other	Diabetes	Glaucoma	Heart Condition	High Blood Pressure	Thyroid
Patient Name (First MI Last)												
Date of Birth: _____ ☐ Male ☐ Female Plan Member (Insured) ID#_____ Relation to Member: ☐ Self ☐ Spouse ☐ Dependent	Describe other allergies or conditions:											

Prescription Info

If you would like Catamaran to contact your physician to request a prescription for you, please provide the information below. Your order will be shipped once we receive the prescription. Remember, you can always view the status of your order online.

Drug Name & Dosage	Doctor Name	Doctor Phone #	Doctor Fax #

If a prescription medication is entered above, but a doctor's prescription is NOT enclosed, we will contact the physician listed.