



Blue Shield of CA – Express Scripts Mail Service Order Form and Patient Profile

If this is the first time you are using this mail service, please fill out this application and send it along with the original prescription(s) to the following address.

Express Scripts, Inc.
PO Box 52123
Phoenix, AZ 85072-2123

Member Name _____ Date of Birth _____
Member ID Number _____ Sex _____
Drug Allergies: None Penicillin Codeine Sulfa Aspirin Other _____

Spouse Name _____ Date of Birth _____
Spouse ID Number _____ Sex _____
Drug Allergies: None Penicillin Codeine Sulfa Aspirin Other _____

Dependent Name _____ Date of Birth _____
Dependent ID Number _____ Sex _____
Drug Allergies: None Penicillin Codeine Sulfa Aspirin Other _____

Address _____ City _____ State _____ Zip _____

Daytime Phone Number (____) _____ Home Phone Number (____) _____

I prefer child resistant caps:

Doctor's Name _____ Phone Number (____) _____

Please Insert Prescription and Payment

PAYMENT INFORMATION:

Check/Money Order VISA MasterCard Discover Card American Express

Credit Card Number _____ Expiration Date _____

Number of prescriptions enclosed _____ Total dollar amount enclosed \$ _____

Please Note and Sign: I certify that the information provided on this form is correct and authorize the release of all information to Blue Shield of California.

To realize cost savings, we will dispense FDA-approved generic medication when allowed by your physician, subject to terms outlined in your plan.

SIGNATURE _____ DATE _____

Refill Prescription Numbers # _____ # _____ # _____