

PLAN MEMBER ORDER FORM



Expatriate Prescription Services

"International Mail-Order For Expatriates"

Telephone: + (540) 777-1450 • Fax: (540) 777-7184

E-Mail: eps@universalrx.com

Date: _____

PLEASE PRINT OR TYPE

Employee Information

Member's Name: _____

Group #: _____

ID #: _____

Patient Information

Patient's Name: _____

DOB: _____ / _____ / _____

Person Code: _____

As shown on your URx prescription card Ex: 01, 02, 03, 04, etc.

Shipping Address: _____

Order for: Employee Spouse Dependent

Contact Phone Number: _____ Fax: _____

International Phone Number: _____

E-Mail: _____

Cannot deliver to a U.S. address or postal box. Please provide a physical address where someone will be available to sign for the package.

Best method of contact: Phone Email Hours: _____

Special Delivery Instruction: _____

Drug Allergies and Medical Conditions: _____

Co-Payment & Shipping Cost Information

Please refer to your benefit outline and formulary for co-pay amounts.

You may pay using Visa, MasterCard, American Express, Money Order or have your co-pay deducted from your checking account.

Credit Card:

Visa MasterCard American Express

Name on Card: _____

Credit Card # _____

Expiration Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Debit Checking Account:

Bank Name: _____

Account Owner: _____

Routing #: _____

Account #: _____

***Please fax or mail a voided check. Fax: 540-777-7184**

Mail to: EPS, 710 3rd Street, Roanoke, VA 24016

Checking account information is currently on file and bank account has not changed.

Debit my account for my co-payment for this order. I hereby authorize Universal Rx to initiate debit entries, and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the account I have indicated and the depository named above.

This authorization is to remain in full force and effect for this order and future orders until written termination is provided by me.

PLAN MEMBER ORDER FORM



Expatriate Prescription Services

"International Mail-Order For Expatriates"

Telephone: + (540) 777-1450 • Fax: (540) 777-7184

E-Mail: eps@universalrx.com

Physician Information

Physician: _____ Address: _____

Telephone: _____

Fax: _____

E-Mail: _____

EPS must have a copy of your prescription to begin processing your order.

How will your prescription be supplied to EPS? Mail Fax E-mail a scanned copy

Order Information

Number of prescriptions enclosed: _____ (Use additional pages if necessary) Childproof caps: Yes No

***A minimum of a 90 day supply and a maximum of 180-day supply are required for all EPS orders.**

All efforts should be made to obtain a prescription in the English language.

Signed prescription from physician is required. EPS may contact your physician to verify prescription.

Name of Drug: _____ Strength: _____ Price: _____
_____ Quantity: _____ Internal Use Only
Spec. Instructions: _____ # Refills Available: _____ Day Supply _____
* Number of days this medication is for

Name of Drug: _____ Strength: _____ Price: _____
_____ Quantity: _____ Internal Use Only
Spec. Instructions: _____ # Refills Available: _____ Day Supply _____
* Number of days this medication is for

Name of Drug: _____ Strength: _____ Price: _____
_____ Quantity: _____ Internal Use Only
Spec. Instructions: _____ # Refills Available: _____ Day Supply _____
* Number of days this medication is for

***EPS will dispense generics whenever possible**

***All Prices in U.S. Dollars**

Print Name: _____

Signature: _____

To order refills you may either call 540-777-1450 or email your order request to eps@universalrx.com

To obtain additional order forms visit our website at www.expats.com

* According to Federal law, prescription medications cannot be returned.

Therefore, EPS is not obligated to accept the return of any goods except in the event of an error on the part of EPS. EPS is not responsible for customs fees nor are we responsible for a package that spoils due to members refusal to pay customs fees.

EPS assumes no liability for the fulfillment of orders.

Internal Use only:

Sub Total: _____

Shipping/Insurance: _____

Total: _____

Pharmacy Code: _____

Order Number: _____

Date Received: _____