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.

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Use one f Additiona

Please rev order can

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.

atient Profile		Drug Allergies					Medical Conditions					
one form per patient. tional forms are available at mycatamaranRx.com. se review your order carefully. Once submitted, an r cannot be cancelled or returned.	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#	Des	scrib	e otl	her a	allerg	gies	or co	ondit	ions	:		
Relation to Member:												

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 #
			-

Order Form (please print)

Patient Name (First MI L	Date of Birth					
Shipping Address*	100 - 10 - 10 - 10 - 10 - 10 - 10 - 10					
City		State	Zip			
Preferred Phone Numbe	Alternate Phone Number					
Member ID #	Group #					
• A physical address (not	a P.O. Box) is typically required	d for temperature-	sensitive medic	ations and controlled substances.		
Shipping Methods:	Normal (no charge)	□ 2nd Day A	ir (\$11.00)	□ Next Day Air (\$25.00)		
Payment Methods: Credit Card Payments Check Cheose one: Money Order One-time use only Visa American Express Discover Discover		Shipp Total State ident	e and federal r tification wher	 \$		
Exp. Date:	5465	substance prescriptions. Please provide one of the following:				
		Drive	r's License:			

State - or -

Social Security #

Contact Us

P.O. Box 166

Member Services

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

Fax: 1.800.893.2299	
Monday-Friday 8am-10pm (EST) Saturday 8am-5pm (EST) Sunday Closed	

Phone: 1.800.763.0044 (TTY: 888.206.8041)

www.mycatamaranRx.com

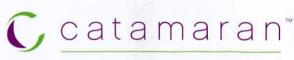
Catamaran Home Delivery

Avon Lake, OH 44012-9927

Catamaran[™] Home **Delivery** for prescription medications



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



stay well ahead