SCHUYLERMEDS
Employee Program

Dependent Form

MEMBER #:

FAX **DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL FREE TO: 1-866-715-(MEDS)6337**

OR

MAIL **TO: SCHUYLERMEDS, P.O. BOX 44650, DETROIT, MI., U.S.A. 48244-0650 PHONE TOLL FREE: 1-866-893-(MEDS)6337**

PATIENT INFORMATION: (please print) Birth date ______________ DD/MM/YYYY

❑ **Spouse**
❑ **Dependent**

Phone (Home) **Phone (Work)**

First Name **Initial** **Last Name**

Street Address

City/State **Zip Code**

NOTE:
Please request a **3-month** supply of medication with **3 refills.**

New-to-you meds must be tried for 30 days before ordering through this program.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements. *Example: Lipitor* *(This is not a prescription.)*	**Strength** *Ex: 10 mg*	**Reason for Taking** *Ex: Cholesterol*	**Daily Use** *Ex: 1 / day*

MEDICAL HISTORY: (If needed, please attach a separate sheet of paper) ❑ **Male** ❑ **Female**

(i) Operations: e.g. Hysterectomy, Gall Bladder, Heart Operations, etc. ______________

(ii) Hospitalization: (stays in hospital past 5 years) ______________

(iii) Present Illness: (ongoing) e.g. Diabetes, Heart Disease, Osteoporosis, etc. ______________

(iv) Drug Allergies: ☐ **NO** ☐ **YES If yes, please specify:** ______________

Physician's Name: **Signature** *(optional)* **Date** *(DD/MM/YY)*

AUTHORIZATION IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18

I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that she/he has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. **I certify that I have read and understand the Terms of Agreement on the reverse and that the information provided above is accurate and true.** I request and authorize Schuyler County, New York, as my appointed agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service as determined appropriate by Schuyler County, New York in the administration of my employment or retirement benefits.

Parent's/Guardian's Signature **Date** *(DD/MM/YY)*

AUTHORIZATION IF THE PATIENT IS THE SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medication for a period of more than 30 days. **I certify that I have read and understand the Terms of Agreement on the reverse and that the information provided by me is accurate and true.** I request and authorize Schuyler County, New York, as my appointed agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service as determined appropriate by Schuyler County, New York in the administration of my employment or retirement benefits.

Patient Signature **Date** *(DD/MM/YY)*