

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

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

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

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

First Name \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

**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**  
 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 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 by me is accurate and true.**

I request and authorize Schuyler County, NY, 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.

Subscriber Signature: \_\_\_\_\_ Date: (DD/MM/YY) \_\_\_\_\_