Department of Veterans Affairs — Meds by Mail Order Form

A mail order prescription service for qualified CHAMPVA and Spina Bifida beneficiaries

This form is for Prescription Orders Only

Important Information:

- This form is to be completed by the patient, family member, or caregiver with power of attorney. It is **NOT** intended to be completed by the medical provider.
- **Fill out the form completely–your Social Security number is very important.** Meds by Mail may need to contact you for further medical information.
- An order form is required **EVERY TIME** a written prescription from your medical provider is mailed to Meds by Mail—**even if you have received the same medication from us in the past.**
- Use a **SEPARATE FORM** for each patient or family member (up to 15 prescriptions can be ordered on each form).
- Attach the original prescription to this form. Photocopies of prescriptions are not accepted.
- Your medication delivery may take up to 21 days from the date you mail your order. Make sure that you **have enough medication on hand to last until your shipment arrives.** You may need to request a second written prescription from your medical provider for a 30 day supply that can be filled at your local pharmacy to meet your immediate needs until the mail order arrives.
- This mail order service is provided only for **MAINTENANCE MEDICATION**—that is, medications that are required for extended periods of time. All short-term or one-time-use prescriptions must be obtained at the local pharmacy of your choice.

How to Request Prescription *REFILLS:*

This order form is for use when you send **hard-copy or written prescriptions** from your medical provider (regardless of whether you have taken the medication in the past). Refill orders are placed using the **REFILL SLIP** that accompanies each shipment of medication. To ensure timely delivery, please return your refill slip as soon as you receive your prescription order. Shipment of medications may take up to 21 days, so **DO NOT DELAY** in requesting your refills. Read the refill slip carefully, it contains information you will need concerning the number of refills remaining and the prescription expiration date.

Where to Mail your Prescriptions:

WEST

If you live in one of the following states or territories, mail your order form to the address listed below:

Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming.

Telephone: 1-888-385-0235

Address: Meds by Mail
PO Box 20330
Cheyenne, WY 82003-7008

EAST

If you live in one of the following districts, states or territories, mail your order form to the address listed below:

Alabama, Connecticut, Delaware, Florida, Georgia, Guam, Kentucky, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Virgin Islands, Washington D.C., West Virginia.

Telephone: 1-866-229-7389

Address: Meds by Mail
PO Box 9000
Dublin, GA 31040-9000

Patient Prescription Information

TYPE or PRINT information below – up to 15 medications per Order Form

Patient Name: (Last, First, Middle Initial)			Patient SSN	Date of Birth (mm/dd/yyyy)

MAILING INFORMATION (TYPE or PRINT where the prescriptions are to be mailed)

Patient Mailing Address:	Daytime Phone Number (Including Area Code):
	Today's Date

Is this a temporary address? ☐ Yes ☐ No

If temporary, what date does the temporary address end (mm-dd-yyyy)?

NON-SAFETY CAP REQUEST:

Federal law requires that your medication be dispensed in a container with a child resistant or safety cap. If you would like your prescription with an "Easy-Open" lid, please sign below:

I request that these prescriptions and all refills of these prescriptions dispensed in "Easy-Open" or NON-child-resistant containers.

Signature: _____ Date: _____

Medication Allergies

- ☐ None
- ☐ Ampicillin
- ☐ Aspirin
- ☐ Cephalosporins
- ☐ Codeine
- ☐ Erythromycin
- ☐ NSAIDS
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (specify)

Health Conditions

- ☐ Asthma
- ☐ Arthritis
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Other (Specify)
- ☐ Ulcer/Acid Reflux/GERD
- ☐ Seizures/Epilepsy
- ☐ Thyroid
- ☐ Seasonal Allergies
- ☐ Food Allergy (Specify)

	Medication Name	Name of Medical Provider Who Signed the Prescription
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

HOW TO OBTAIN MORE ORDER FORMS: You may either photocopy a blank form, or call the VA Health Administration Center at 1-800-733-8387. Forms are also available on the website: **www.va.gov/hac/forms**