OHSU MAIL ORDER PHARMACY SERVICE
PRESCRIPTION REFILL REQUEST FORM

FOR MORE INFORMATION, VISIT US AT WWW.OHSUHEALTH.COM/PHARMACY

Please complete this form and return it to the following address:

OHSU Mail Order Pharmacy
9315 SW Nimbus Ave
Beaverton, OR 97008

OR

Fax to OHSU Mail Order Pharmacy:
503-346-3371
mailorder@ohsu.edu

Today's Date:

PATIENT NAME & ADDRESS

Last Name:	First:	Middle:	Birth Date:	Sex: ☐ M ☐ F
Street Address:		Apt:	P.O Box:	E-mail Address:
City:	State:	Zip Code:	Phone #: ( ) -	

PATIENT PROFILE

☐ **No Changes** (check if no changes since last order)

Prescription Plan Name:			Member ID:
Rx Group:	Rx Bin:	Rx PCN:	Member Services Contact #: ( ) -

Drug Allergies: ☐ None ☐ Codeine ☐ Penicillin ☐ Iodine ☐ Aspirin ☐ Erythromycin ☐ Sulfa

☐ Other Allergies:

Health Conditions: ☐ Diabetes ☐ Heart Condition ☐ Thyroid-Low/High ☐ Arthritis ☐ Depression ☐ High Blood Pressure ☐ Asthma ☐ Glaucoma ☐ High Cholesterol

☐ Other Conditions:

PRESCRIPTION REFILL REQUEST INFORMATION

Prescription Number	Drug Name & Strength (optional)	Prescription Number	Drug Name & Strength (optional)

Delivery Options: Please indicate how you would like to receive your medications.

Deliver to Home Address: ☐

Courier Service to: ☐ Physician's Pavilion Pharmacy ☐ CHH (Waterfront) Pharmacy ☐ Doernbecher Pharmacy ☐ Casey Eye Institute Pharmacy ☐ Gabriel Park Pharmacy ☐ Beaverton CHO Pharmacy

Payment Information – Credit Card

To authorize payment by credit card, provide the account number, expiration date. and cardholder's signature. We accept Discover, MC, Visa, and Amex. This card will be used for this and all future orders, unless we are notified otherwise.

Credit Card Number: | | | | | - | | | | | - | | | | | - | | | | |

Expiration Date (MM/YY): | | / | | |

CVV Number (On back of the card): | | | |

Signature of Patient/Guarantor

Date