

# Health Direct Pharmacy Services

**about us...** Health Direct Pharmacy Services, located at 31 East Main Street in Gouverneur, New York 13642, is a division of Kinney Drugs, Inc. and like Kinney Drugs, Health Direct Pharmacy Services is committed to providing its customers with superior customer service and convenient access to our products and services. You can contact Health Direct Pharmacy Services, toll-free at **1-866-287-9885**



## Order Form

Detach and return along with your prescription(s) and any necessary co-payment in the postage paid envelope.

INSURED FAMILY MEMBER'S NAME \_\_\_\_\_  
PLAN NAME \_\_\_\_\_ MEMBER ID NO. \_\_\_\_\_

### SHIP TO:

ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PLEASE CHECK THE APPROPRIATE DESIGNATION:  PERMANENT ADDRESS  SEASONAL ADDRESS  TEMPORARY ADDRESS  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

### COMMENT/REFILL REQUESTS

Provide prescription numbers for refill and/or any other information to help insure the accurate and timely processing of your order.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PRESCRIPTIONS ENCLOSED FOR:

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
RELATIONSHIP TO INSURED:  SELF  SPOUSE  DEPENDENT SEX:  M  F  
NUMBER OF PRESCRIPTIONS ENCLOSED (INCLUDE BOTH NEW AND REFILL) \_\_\_\_\_ TOTAL CO-PAY (THIS INDIVIDUAL) \_\_\_\_\_

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NUMBER OF PRESCRIPTIONS ENCLOSED (INCLUDE BOTH NEW AND REFILL) \_\_\_\_\_ TOTAL CO-PAY (THIS INDIVIDUAL) \_\_\_\_\_

### METHOD OF PAYMENT

TOTAL CO-PAY (ENTIRE ORDER) \_\_\_\_\_  CHECK OR MONEY ORDER ENCLOSED (MAKE PAYABLE TO **HEALTH DIRECT PHARMACY SERVICES**)  
 AMERICAN EXPRESS  VISA  MASTERCARD  DISCOVER  KINNEY COURTESY CARD  
CARD NUMBER \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_  
CARDHOLDER SIGNATURE \_\_\_\_\_

# Getting Started

To receive medications from Health Direct Pharmacy Services you must first establish a patient profile. To do that you may:

a) Enclose a completed **patient profile form** in the postage paid envelope the first time your order a medication.

~ or ~

b) Call our customer service representative toll free at **(866) 287-9885** to establish your profile ahead of time.

Once your profile has been established, it is no longer necessary to complete a **patient profile form** to order medications, unless you need to inform Health Direct Pharmacy Services of any changes in your medical history.

## Notice of Privacy Practice

You will be sent Health Direct Pharmacy Services Notice of Privacy Practices the first time you receive an order. Federal law mandates that the pharmacy retain your signature acknowledging the receipt of that notice. After you receive the notice, please sign the acknowledgment and return it with your next order.

## Ordering New Medications

When you receive a new written prescription from your doctor for up to a 90 day supply of medication, simply:

- 1.) Complete an **order form** making sure to indicate where you would like the prescription shipped and verify which of your family members it is for. Then...
- 2.) Send the **original prescription**, the completed **order form** and any necessary co-payment to Health Direct Pharmacy Services in the postage paid envelope.

## Ordering Refills

Once you have placed your original order and need a refill, you can do any of the following:

- a) Order your refill on-line at **www.healthdirectpharmacy.com**
- b) Order your refill toll free by phone at **(866) 287-9885** on the 24 hour automated refill system
- c) Order your refill by mail with an **order form** in the postage paid envelope.

## Profile Form

### INSURED FAMILY MEMBER

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SEX  M  F  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
LIST KNOWN DRUG ALLERGIES \_\_\_\_\_  
LIST KNOWN MEDICAL CONDITIONS \_\_\_\_\_

### SPOUSE

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SEX  M  F  
LIST KNOWN DRUG ALLERGIES \_\_\_\_\_  
LIST KNOWN MEDICAL CONDITIONS \_\_\_\_\_

### DEPENDENT

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SEX  M  F  
LIST KNOWN DRUG ALLERGIES \_\_\_\_\_  
LIST KNOWN MEDICAL CONDITIONS \_\_\_\_\_

### DEPENDENT

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SEX  M  F  
LIST KNOWN DRUG ALLERGIES \_\_\_\_\_  
LIST KNOWN MEDICAL CONDITIONS \_\_\_\_\_

### RECEIPT OF PRIVACY PRACTICES

I acknowledge receipt of the Health Direct Pharmacy Services Notice of Privacy Practices.

\_\_\_\_\_  
SIGNATURE OF INSURED FAMILY MEMBER

\_\_\_\_\_  
PRINTED NAME OF INSURED FAMILY MEMBER

\_\_\_\_\_  
DATE