## **Mail Order Form**



## Questions? Call (866) 516-1121

701 Emerson Road, Suite 301 Creve Coeur, Missouri 63141 www.LDIRx.com

## Instructions

## **LDI Home Advantage**

- 1. Verify that each Patient's Name, Telephone Number and Date of Birth are clearly written on each prescription.
- 2. Verify that the Physician's Name, Address and Phone Number are clearly written on each prescription.
- 3. Complete all sections of this form and place it along with the original prescription(s) in an envelope.

4. Enclose check, money	y order or credit card information (orders will not be mai	iled until payment i	s received).
Patient Information	on		
Patient One Last Name	F	First Name	
Member ID	Date of Birth	Email	
Wellider 1D		Littan	
Phone Number	Alternate Phone Number	Se	ex
-		M	ale Female
Patient Two (If there is n Last Name	to additional patient, skip to Prescription Information)	irst Name	
Member ID	Date of Birth	Email	
	MM-DD-YYY	Υ	
Phone Number	Alternate Phone Number	Se	
	<u></u>	IVI	ale Female
Prescription Information			
Please enclose your new <b>Patient One</b>	w prescription(s) in the envelope. To refill existing prescription	criptions, fill out the	e information below.
Rx Number	Medication Name and Strength	Quantity	Days Supply
<b>Patient Two</b>			
Rx Number	Medication Name and Strength	Quantity	Days Supply
Shipping Address	(Allow 4-7 business days for mailing after order has been processed)		
Address			
City	State	e Zip Code	

# **Additional Information**



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Physician Information				
Physician Last Name Physi	nysician Phone Number			
Physician Last Name Physi	cian Phone Number			
Allergies and Other Health Conditions				
Please list any allergies.				
Please list any health conditions.				
Billing Address Check if your Billing Address is the same as your Shipping Address				
Address				
City State	Zip Code			
Method of Payment (No order will be mailed until payment has been received)				
Credit / Debit Card				
VISA  DISCOVER  DISCOVER  DISCOVER  C A R D				
Card Number Expiration Date	CVV2 Code			
Name (As it appears on card)				
Authorized Signature				
X X				
Check by Phone (\$0.50 fee) Checking Account Number Routing Number	Check / Money Order Amount Enclosed			
Checking recount runner roung runner	Timodit Erelosed			
Check Number	Please make checks payable to LDI Pharmacy Services.			
	to LDI Pharmacy Services.			
Signature (Signature is required to process order)				
I authorize the release of any medical information required to process this claim.	Date of Signature			
	MM - DD - YYYY			
Dispense generics as permitted by law. I request brand name only. I request to	non-child resistant caps on all medication.			
Please check here if you have questions regarding your medication and would like a pharmacist to contact you.				
Comments or Special Instructions				

Mail Completed Order Form, Original Prescriptions and Payment to:
LDI Integrated Pharmacy Services,
701 Emerson Road, Suite 301, Creve Coeur, MO 63141

