

Geisinger Mail Order Pharmacy
 210 Industrial Park Road, Elysburg, PA 17824
 Phone: 844-878-5562
 Hours: Monday – Friday, 6:30 a.m. – 7 p.m.
 Closed Saturday, Sunday and holidays



DO NOT SUBMIT USING THE INTEROFFICE MAIL SYSTEM.

Please ask your provider to submit new prescriptions electronically. If necessary, prescriptions can be mailed via US Mail to our address above.

*CARDHOLDER INFORMATION as it appears on insurance card			*indicates a required field	
First name	MI	Last name	Suffix	Date of birth (mm/dd/yyyy)
Permanent address:			City:	
State:	Zip code:	Email address (for shipping notification):		
Preferred phone number Home:	Cell:	Alternative phone number Home:	Cell:	
Cardholder ID:		Group ID:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Drug allergies: <input type="checkbox"/> None <input type="checkbox"/> Codine <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other:				

SECONDARY INSURANCE — Cardholder information as it appears on insurance card				
First name	MI	Last name	Suffix	Date of birth (mm/dd/yyyy)
Permanent address:			City:	
State:	Zip code:	Email address (for shipping notification):		
Preferred phone number Home:	Cell:	Alternative phone number Home:	Cell:	
Cardholder ID:		Group ID:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Drug allergies: <input type="checkbox"/> None <input type="checkbox"/> Codine <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other:				

*** ADDITIONAL FAMILY MEMBERS:** (IF YOU NEED TO ADD MORE ADDITIONAL FAMILY MEMBERS, please use a separate piece of paper. Please include all of the information that is requested on this form.)

First name	MI	Last name	Suffix	Date of birth (mm/dd/yyyy)
Permanent address:			City:	
State:		Zip code:		
Relationship to cardholder: <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Drug allergies: <input type="checkbox"/> None <input type="checkbox"/> Codine <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other:				
First name	MI	Last name	Suffix	Date of birth (mm/dd/yyyy)
Permanent address:			City:	
State:		Zip code:		
Relationship to cardholder: <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Drug allergies: <input type="checkbox"/> None <input type="checkbox"/> Codine <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other:				
First name	MI	Last name	Suffix	Date of birth (mm/dd/yyyy)
Permanent address:			City:	
State:		Zip code:		
Relationship to cardholder: <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Drug allergies: <input type="checkbox"/> None <input type="checkbox"/> Codine <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other:				

PRESCRIPTION INFORMATION: Check when applicable

I would like to enroll in "Auto Refill" I would like an easy open cap I do NOT want a generic drug medication.

*It is standard pharmacy practice to substitute generic drugs for chemically equivalent brand-name drugs when possible. You have the right to refuse such substitution. **Choosing a brand-name drug when a generic is available may result in a higher cost.***

PENNSYLVANIA LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG FOR A BRAND NAME DRUG UNLESS YOU OR PHYSICIAN DIRECT OTHERWISE. CHECK HERE IF YOU DO NOT WISH A LESS EXPENSIVE BRAND OR GENERIC DRUG "PRODUCT".

***SHIPPING INFORMATION** for mail order prescriptions:

- Your order will be shipped standard delivery at no charge. Please allow 7 to 10 BUSINESS days for delivery of your medicine. If you prefer expedited delivery, check the next business day option below.
- All medication will be shipped to the permanent address provided unless otherwise specified below:
- Next business day – Federal Express (\$16 per order) – No P.O. boxes accepted.

Ship to another address

Name:			
Address:			
City:			
State:		Zip code:	

- *Payment information and cardholder signatures required for ALL mail order prescriptions:
- *Cash is not accepted for mail order.

PRIMARY CREDIT CARD: (Will be applied to all patients unless otherwise indicated in "Additional Comments Section")

Master Card Visa Discover Flexible Spending Account Debit Card

*Credit card number: _____ *Credit Card expiration date: Month: _____ Year: _____ CVV: _____

First name	MI	Last name	Suffix	Date of birth (mm/dd/yyyy)
Permanent address:				
City:		State:		Zip code:

*Cardholder signature (**REQUIRED**): _____

This card will be charged for drug costs and expedited shipping (if applicable).

SECONDARY CREDIT CARD: (Will be applied to all patients unless otherwise indicated in "Additional Comments Section")

Master Card Visa Discover Flexible Spending Account Debit Card

*Credit card number: _____ *Credit Card expiration date: Month: _____ Year: _____ CVV: _____

First name	MI	Last name	Suffix	Date of birth (mm/dd/yyyy)
Permanent address:				
City:		State:		Zip code:

*Cardholder signature (**REQUIRED**): _____

This card will be charged for drug costs and expedited shipping (if applicable).

RETENTION OF CREDIT CARD INFORMATION: Would you like us to keep your credit card information on file electronically in a secure format for future use? (**Check one**) Yes No

ADDITIONAL COMMENTS SECTION: (Please use this space, if needed, for additional contact information or billing instructions.)

By returning this form to Geisinger Mail Order Pharmacy, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers and their agents for health benefits management. If you have any questions, please contact us at 844-878-5562. Thank you for utilizing Geisinger Mail Order Pharmacy. We look forward to serving your prescription needs.