Health First
Family Pharmacy

Order Form

Phone 321.434.7355 **Toll Free 866.469.1506**
Fax: Holmes Regional Medical Center 321.434.6105
Fax: Health First Medical Group – Gateway 321.409.6861
Fax: Viera Hospital Medical Plaza 321.434.9534

Please fill out one form for every person filling a medication.

Delivery/Pick Up Options *(Please allow 48 hours to process and mail out or deliver.)*

☐ **Pick up** at Health First Family Pharmacy:
☐ **Holmes Regional Medical Center** (1350 S. Hickory Street, Melbourne)
☐ **Health First Medical Group – Gateway** (1223 Gateway Drive, Melbourne)
☐ **Viera Hospital Medical Plaza** (8725 N. Wickham Road, Suite 102, Melbourne)

☐ **Mail** to this address _____

☐ **Courier** to Health First facility (for associates only, contact us for delivery locations) _____

Customer and Insurance Information *(Please provide the following from your insurance ID card.)*

Member Name_____ Member ID # _____
Member DOB_____ Rx Bin_____ Rx PCN_____ Rx Group _____
Member Address _____
City, State, Zip_____ Phone _____

Health History *(Complete on first fill and when information has changed.)*

Does the patient have any of the following allergies or health conditions?
☐ Aspirin Allergy ☐ Sulfa Allergy ☐ Penicillin Allergy ☐ None ☐ Other Allergy(s) _____
☐ Diabetes ☐ Epilepsy ☐ Glaucoma ☐ Heart condition ☐ High Blood Pressure ☐ Thyroid ☐ Ulcer
☐ Other condition(s) _____

New Prescriptions *(Please attach a copy of the original prescription signed by your doctor.)*

	Medication Name	Prescribing Physician	
❶			☐ Fill Now ☐ Hold
❷			☐ Fill Now ☐ Hold
❸			☐ Fill Now ☐ Hold
❹			☐ Fill Now ☐ Hold

Transfer Prescriptions

	Medication Name	Pharmacy Name / Phone	Prescription Number	Supply (days)
❶				☐ 30 ☐ 90
❷				☐ 30 ☐ 90
❸				☐ 30 ☐ 90
❹				☐ 30 ☐ 90

Refill Prescriptions

	Medication Name	Prescription Number		Medication Name	Prescription Number
❶			❸		
❷			❹		

Payment Information (Required for Mail Order Home Delivery)

Credit Cards Only (No Debit Cards) ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ FSA Card
Name on Card_____ Card Number _____
Expiration Date_____ CVV Code (3-digit code on back of card) _____
Cardholder Signature _____ ☐ Please keep this credit card on file for future orders

Authorization

I represent that the information on this form is correct, and authorize the release of information regarding medical and prescription drug history and treatment to Health First Family Pharmacy.
☐ I have read and accept the Health First Joint Notice of Privacy Practices at www.Health-First.org/NOPP.

Signature_____ Date _____

Revised 11/18/2015