Integrated HMO Pharmacy
A Division of Pharmaceutical Technologies Inc.®

Mail Order Switch Form

Welcome to Integrated HMO (IHMO) Pharmacy! The purpose of this form is to switch any existing prescriptions that still have remaining refills from your current pharmacy to the IHMO Pharmacy. To make the switch easier, please complete and return this form to the address listed at the bottom of the page and the IHMO Pharmacy will contact your healthcare provider for the proper instructions on how to refill your prescription(s). **A separate form must be filled out for each covered member of the household.** The switch process and the receipt of any requested refills can take 21 to 30 days, so please make sure you have an adequate supply of your current medications. If you need to fill "new" mail order prescriptions or have any questions, please contact IHMO Pharmacy at: P.O. Box 369, Boys Town, NE 68010-0369 • 1-800-633-7928 • IHMO@pti-nps.com

Employer Information

Employer name

Group number

Employee Information

Employee name

ID number

Work ph. # ( ) Ext#

Home ph. # ( )

Street address (no P.O. boxes please) Apt #

City

State

Zip code

Patient Information

Patient name

Phone # ( )

Date of birth (MM/DD/YY)

Please list any medication allergies:

Shipping address (if different from employee address)

Street address (no P.O. boxes please) Apt #

City

State

Zip code

Method of Payment

Please note that payment is due at the time of refill. Please check your method of payment below. If you are paying by credit card and your information is already on file at the IHMO Pharmacy, simply check the appropriate box below. Otherwise, please provide your credit card information **(debit cards are not accepted)**.

❑ Check ❑ Money order or cashier's check ❑ Credit card information on file at IHMO

❑ MasterCard ❑ VISA ❑ DISCOVER NETWORK

Credit card # Exp. date (MM/YY)

Name as it appears on card

I understand all co-payments and "special" shipping and handling costs for prescription benefits purchased through Integrated HMO Pharmacy will be charged to the credit card provided above. I also understand by signing this form, all prescription medications cannot be returned to the pharmacy for credit unless in response to a recall, defect in a medical device, or otherwise pre-approved by the pharmacy. A return of medication for any other reason shall result in its immediate destruction and shall not be available for credit.

Signature of cardholder Date (MM/DD/YY)

Pharmacy Information

Prescription #1 ❑ **Switch and refill now** ❑ **Switch and hold (member must contact the IHMO Pharmacy to refill later)**

Medication name

Prescription #

Pharmacy name

Prescriber name

Prescriber phone # ( )

Prescription #2 ❑ **Switch and refill now** ❑ **Switch and hold (member must contact the IHMO Pharmacy to refill later)**

Medication name

Prescription #

Pharmacy name

Prescriber name

Prescriber phone # ( )

Prescription #3 ❑ **Switch and refill now** ❑ **Switch and hold (member must contact the IHMO Pharmacy to refill later)**

Medication name

Prescription #

Pharmacy name

Prescriber name

Prescriber phone # ( )

Mail or fax this completed form to: **Integrated HMO Pharmacy • P.O. Box 369 • Boys Town, NE 68010-0369 • Fax: 1-800-801-2395**