Department of Veterans Affairs — Meds by Mail Order Form

A mail order prescription service for qualified CHAMPVA and Spina Bifida beneficiaries

This form is for Prescription Orders Only

Important Information

- ***This form must be filled out completely including your Social Security number and Date of Birth for identification purposes. If you cannot be identified, your prescription will not be filled.***
- This form is to be completed by the patient, family member, or caregiver with power of attorney.
- Use a separate form for each patient or family member.
- This order form is required **EVERY TIME** a written prescription from your medical provider is mailed.
- Attach the original prescription to this form. Photocopies of prescriptions are not accepted.
- Your medication delivery may take up to **21 days** from the date you mail your order. To ensure that you have enough medication to last until your shipment arrives, you may need to request a second written prescription from your medical provider that can be filled at your local pharmacy.
- This mail order service is provided only for maintenance medication—that is, medications that are required for extended periods of time. All short-term or one-time-use prescriptions must be obtained at your local pharmacy.

How to Request Prescription *REFILLS:*

This form is for use when you send a **paper prescription** written by your medical provider. Refill orders should be placed by calling our automated refill system. Simply call 1-888-370-1699 and follow the voice prompts. Refill orders may also be placed using the refill slip that accompanies each shipment of medication. If you choose to reorder by mail, be sure to return your refill slip as soon as you receive your prescription order, as it may take up to **21 days** to process your order. **DO NOT DELAY** in requesting your refills. Read the refill slip carefully, it contains information you will need concerning the number of refills remaining and the prescription expiration date.

Where to Mail your Prescriptions:

WEST

If you live in one of the following states or territories, mail your order form to the address listed below:

Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming.

Telephone: 1-888-385-0235

Address: Meds by Mail
PO Box 20330
Cheyenne, WY 82003-7008

EAST

If you live in one of the following districts, states or territories, mail your order form to the address listed below:

Alabama, Connecticut, Delaware, Florida, Georgia, Guam, Kentucky, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Virgin Islands, Washington D.C., West Virginia.

Telephone: 1-866-229-7389

Address: Meds by Mail
PO Box 9000
Dublin, GA 31040-9000

Patient Prescription Information

This form must be filled out completely - TYPE or PRINT information below:

Patient Name: (Last, First, Middle Initial)	Patient SSN	Date of Birth (mm-dd-yyyy)

MAILING INFORMATION (TYPE or PRINT where the prescriptions are to be mailed)

Patient Mailing Address:

Daytime Phone Number (Including Area Code):

Home: Cell:

Today's Date

Is this a change of address? ☐ Yes ☐ No

Is this a permanent change? ☐ Yes ☐ No

Is this a temporary change? ☐ Yes ☐ No

If temporary, what date does the address end (mm-dd-yyyy)?

NON-SAFETY CAP REQUEST:

Federal law requires that your medication be dispensed in a container with a child resistant or safety cap. If you would like your prescription with an "Easy-Open" lid, **please sign below**:

I request that these prescriptions and all refills of these prescriptions dispensed in "Easy-Open" or NON-child-resistant containers.

Signature: Date:

Medication Allergies

☐ None
☐ Ampicillin
☐ Aspirin
☐ Cephalosporins
☐ Codeine
☐ Erythromycin
☐ Morphine
☐ SAIDS
☐ Penicillin
☐ Sulfa
☐ Tetracycline
☐ Other (specify)

Health Conditions

☐ Arthritis
☐ Asthma
☐ COPD
☐ Depression
☐ Diabetes
☐ Glaucoma
☐ High Cholesterol
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Seasonal Allergies
☐ Seizures/Epilepsy
☐ Thyroid
☐ Ulcer/Acid Reflux/ GERD

☐ Other (Specify)

☐ Food Allergy (Specify)

	Medication Name	Name of Medical Provider Who Signed the Prescription
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

HOW TO OBTAIN MORE ORDER FORMS: You may either photocopy a blank form, or call the VA Health Administration Center at 1-800-733-8387. Forms are also available on the website: **www.va.gov/hac/forms**