RIDGEWAY
MAIL ORDER
PHARMACY

2824 US Hwy 93 North • Victor, MT 59875
642-6040 Local •1-800-630-3214 Toll Free
406-642-6050 Fax
www.ridgewayrx.com

Welcome to your mail pharmacy benefit program.

Your insurance carrier has teamed up with Ridgeway Pharmacy to offer you a mail service pharmacy. Ridgeway Pharmacy's mail service pharmacy program offers mail service, exceptional customer service, and is based out of Montana's Bitterroot Valley. If you have questions about your mail service pharmacy benefit, please call Ridgeway at **1-800-630-3214**. If convenient, please send a copy of your insurance card.

Member Information

Member ID# _____ Employer _____

Insurer _____

Last name _____ First name _____ Middle Initial _____ Sex _____

Soc. Sec. # _____

Mailing address _____ Apt. or Suite _____

City _____ State _____ Zip _____

Physical address _____ Apt. or Suite _____

City _____ State _____ Zip _____

Birthdate (mo/day/yr) _____ ( ) Daytime Phone # _____ ( ) Evening Phone # _____

E-mail address: (Optional) _____

Drug Allergies

- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

Other health conditions or drug allergies:

I prefer "easy open" caps
❑ Yes ❑ No

Primary Physician Information

Last name _____ First name _____ ( ) Phone # _____

Method of Payment

❑ Visa ❑ MasterCard

Credit Card Number _____ Expiration Date _____

❑ Please Bill Me

Signature _____

PLEASE READ AND SIGN: I certify that the information provided on this form is current and I AUTHORIZE RIDGEWAY PHARMACY TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE, IN ACCORDANCE WITH APPLICABLE LAW, CONSISTENT WITH MY DOCTOR'S ORDERS. BALANCES OLDER THAN 90 DAYS WILL BE SUBJECT TO ALL COLLECTION FEES, AND/OR ATTORNEY FEES.

Member's Signature _____ Date Signed _____

For new mail service prescriptions, please follow these simple steps:

1. If you need to start your medication right away, have your physician complete two prescriptions. Please be sure the prescription from your physician is legible, includes the drug's name, strength, the quantity to dispense, the exact daily dosage, the physicians' name and phone number.

2. Fill one prescription immediately at a pharmacy and submit the other to the Ridgeway Pharmacy mail service program for a supply determined by your benefit plan. Encourage your physician to write your prescription for the maximum days supply covered by your benefit plan. This will help you maximize your benefit and save money.

3. Complete the mail service participant profile. Please be sure to write your participant ID number in the space provided on the profile. If your benefit plan includes dependent coverage, please fill out the dependent section(s), even if you are not ordering medications for them at this time. If more space is needed for dependents, please list them on a separate sheet.

4. Mail the participant profile and original prescription(s) to Ridgeway Pharmacy.

Dependent #1 ❑ Spouse ❑ Child

Last Name

First Name Middle Initial

Birthdate (mo/day/yr) Sex

Other health conditions and drug allergies:

Primary Physician Information

( )

Last Name First Name Phone #

Drug Allergies
- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

Dependent #2 ❑ Spouse ❑ Child

Last Name

First Name Middle Initial

Birthdate (mo/day/yr) Sex

Other health conditions and drug allergies:

Primary Physician Information

( )

Last Name First Name Phone #

Drug Allergies
- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)

Dependent #3 ❑ Spouse ❑ Child

Last Name

First Name Middle Initial

Birthdate (mo/day/yr) Sex

Other health conditions and drug allergies:

Primary Physician Information

( )

Last Name First Name Phone #

Drug Allergies
- ❑ None
- ❑ Aspirin (03)
- ❑ Codeine (04)
- ❑ Erythromycin (09)
- ❑ Iodine (29)
- ❑ Penicillin (01)
- ❑ Sulfa (15)