Cleveland Clinic Pharmacy

Cleveland Clinic Pharmacies/Home Delivery Service: **Processing Form**

Date: _________/_______/_________

Patient Name: ___________________________________

Patient Date of Birth: ____/_____/____

Contact Phone No.: _________________________________

Alternate Phone No.: _______________________________

Primary Shipping Address:

Street: ____

City/State/Zip: __________________________________

Email: ____

Patient Medical Record No.: _________________________

Prescription Insurance: _____________________________

____

____

Patient Address:

Street: ____

City/State/Zip: ____________________________________

List prescriptions being filled (*name or Rx number*):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Is Generic OK? ❑ Yes ❑ No, Brand Name is requested

*If these are prescriptions from another pharmacy, please indicate the following:

Name and Phone No. of Pharmacy:

____

____

Rx Number(s) or Name(s) of Medications:

____

____

____

Drug Allergies (*please list*): ____

Payment Method: At what amount would you like us to contact you before processing your order? $ ____________

❑ **FSA Card (PayFlex):** Please also indicate an alternate form of payment should there be an insufficient balance. If PayFlex is your primary choice for payment, we will need a credit card to process any balance in excess of the PayFlex card.

FSA Card # ____

Exp. Date: ______________________

Signature: ____

❑ **Credit Card (Visa/Mastercard/Discover/AMEX)**

Credit Card # _______________________________

Exp. Date: ______________

Signature: __________________________________

Employees Only:

Employee Name: ______________________________ Prescription Insurance ID No.: ________________________

Employee ID Badge No.(*Required*):_______________Badge Encoded No.:_________ (*6 digit number on back of ID badge*)

❑ **Payroll Deduction**

I understand that my badge is the property of the Cleveland Clinic Foundation and must be returned to the ID badge Department upon termination of employment or upon request by the Cleveland Clinic Foundation. I further understand that I will be responsible for all charges made with this badge and I hereby authorize those charges to be deducted from my paycheck. Charges made during a payroll period will be reflected as “Pharmacy” on the corresponding paycheck stub. Furthermore, I agree to protect this badge from unauthorized use and to pay Cleveland Clinic Pharmacies any outstanding balance upon termination of my employment or withdrawal from this program. I recognize that any unauthorized and/or illegal use of any badge is classified as a major infraction and will be grounds for disciplinary action in accordance with CCF Policy 121.

I have read the above information and agree to all of the above and authorize use of payroll deduction for the entire amount due.

Employee Signature: ____Date:___/___/___

***Note:** Any amount of $0-$99.99 will be deducted in 1 pay cycle. Any amount of $100.00 or more will be deducted over 6 pay cycles.

Phone: 216-448-4200
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Toll Free: 1-855-276-0885
Website: www.clevelandclinic.org/pharmacy
MyRefills: myrefills.clevelandclinic.net

Mail to: Cleveland Clinic Home Delivery Pharmacy
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Cleveland, OH 44195