Einstein LiveWell Pharmacy Home Delivery Enrollment Form

Please fax your completed form to the Pharmacy at 215-456-4662.

*Express Scripts ID Number		*Date			
PATIENT 1 (CARDHOLDER)					
*Einstein Employee Number:					
*First Name, Middle Initial, Last Name					
*Date of Birth (MM/DD/YYYY)		*Gender: (circle one)	Male / Female		
*Shipping Address 1:					
*Shipping Address 2:					
*City:		*State:		*Zip Code:	
E-mail address:					
*Please select one as your preferred telephone number:		Daytime Phone:			
		Evening Phone:			
		Cell Phone:			
*Allergies					
*Please indicate the following:	Use Home Delivery for **ALL** future prescriptions [ ]	Use Home Delivery This Time **ONLY** [ ]			
PATIENT 2					
*First Name, Middle Initial, Last Name					
*Date of Birth (MM/DD/YYYY)		Gender: (circle one)	Male / Female		
*Shipping address:					
*Allergies					
PATIENT 3					
*First Name, Middle Initial, Last Name					
*Date of Birth (MM/DD/YYYY)		Gender: (circle one)	Male / Female		
*Shipping address:					
*Allergies					
***Are you requesting childproof caps?** (Check one) ____ Yes ____ No					
PLEASE FILL OUT ITEMS BELOW IF YOU ARE TRANSFERRING FROM A PREVIOUS PHARMACY					
*Please provide your previous Pharmacy's information	*Pharmacy Name:				
	*Pharmacy Phone Number:				

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts, Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required: X____

PENNSYLVANIA LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG FOR BRAND NAME DRUG UNLESS YOU OR YOUR PHYSICIAN DIRECT OTHERWISE.

☐ (CHECK BOX IF APPLICABLE.) I DO NOT WANT A LESS EXPENSIVE BRAND OR GENERIC DRUG PRODUCT. I UNDERSTAND THAT BY SELECTING THIS STATEMENT, I MAY INCUR ADDITIONAL COSTS ACCORDING TO THE GUIDELINES OF MY PRESCRIPTION PLAN. WRITE 'BRAND ONLY' ON THE BACK OF ANY PRESCRIPTION YOU WANT TO RECEIVE AS A BRAND MEDICATION.