

Hershey Medical Center Outpatient Pharmacy For Information visit our Web site at: www.pennstatehershey.org/pharmacy

Phone: (717) 531-3909 Fax: (717) 531-0110

EMPLOYEE PREFERRED PRESCRIPTION DRUG PROGRAM ORDER FORM

Instructions: Please complete all the information listed on this form. Mail or drop off this completed form and doctor's prescription(s) to the following address: PSHMC Outpatient Pharmacy, Mail Code HU21, 500 University Drive, Hershey, PA 17033

Drop off box is located outside UPC Suite 1200

Patient Information						
Primary Member Cardholder ID number (Refer to Primary Member Cardhol	rescription Card):					
Patient Name:		Name of Cardholder:				
Date of Birth:	Allergies:					
Contact Number:	_	Permission to leave mes	ssage:	Yes	No	
New Prescriptions: Number of New Prescript	ions:					
Refills:						
List Prescription Numbers and Corresponding Med	ication Names		Do You Yes	u Want Sa No	fety Caps?	
Method of Delivery (select one): Please allow 5	i-7 Business D	ays for Processing, Unle	ss Other	wise Noti	fied	
If mail is selected a credit card number <u>must</u> be pr						
different patients within the same household will be Mail: Use Credit Card On File	mailed collective	ely in same package uniess	indicated	otnerwise	in comments section below	
Mail: Credit Card Number (MC/Visa/Disc):					Exp Date:	
Name on Credit Card:						
Mailing Address:						
City:						
Pick-up: email address for notification:						
Comments:						
***************************************	*******	*********	******	******	************	
Consent to store Credit Card Information: Employees of give permission for PennState Hershey Pharmacy to store charged to the card will vary based on the prescription medicard (i.e. new card, new exp. date). The following family medicard (i.e. new card, new exp. date).	e my credit card for lication. I understa	use in processing future mail on that it is my responsibility to	contact the	e pharmacy		
Employee Name:		Employee [Employee Date of Birth (DOB):			
Family Member:	DOB:	Family Member:			DOB:	
Family Member:	DOB:	Family Member:			DOB:	
Signature:	****	Date:	*****	****	*********	
Pharmacy Use Only: Card Type: VISA MC DISCOVER					P Pharm #1 Rev 11/2012	