

DETACH HERE

Profile and Drug Allergy Information

Please complete this form (both sides) and return it to RxDN. Be sure to sign the form, and enclose your prescription(s). If you or any of your eligible family members have any drug allergies, please list the drug allergies under the appropriate name.

RxDN
P.O. Box 137
Bristol, PA 19007
1-800-800-8769

Local Fund No. _____ I.D./Social Security Number _____

Group Name _____

Cardholder's Name _____ Sex: M F

Address _____
Street City State Zip

Home Phone No. _____ Work Phone No. _____ Date of Birth _____
Area Code Area Code

Doctor's Name _____ Telephone No. _____
Area Code

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Don't Send This Form Until You Send A Prescription

PROFILE INFORMATION—Continued Please complete the following section for all eligible family members.

Name _____	Date of Birth _____	Member _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>
List Drug Allergies _____			
Name _____	Date of Birth _____	Relationship To Member _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>
List Drug Allergies _____			
Name _____	Date of Birth _____	Relationship To Member _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>
List Drug Allergies _____			
Name _____	Date of Birth _____	Relationship To Member _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>
List Drug Allergies _____			

I HEREBY CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT AND I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES. I AUTHORIZE RELEASE OF ALL INFORMATION TO RxDN

Date _____ Cardholder Signature _____

Number of Prescriptions Enclosed with this profile _____ Do you require safety cap? Yes No