

HealthPartners mail order pharmacy is quick and easy! There are three ways to fill or refill a prescription, transfer in a prescription or check if your prescription is ready:

1. Visit us online at **healthpartners.com/mailorder**
2. Call us at **612-623-4002** or **800-591-0011**.
3. Complete the form below. New original prescriptions can be mailed to the pharmacy by you or your doctor. All faxed or phoned in new prescriptions can only be delivered by the prescribing doctor.

Questions? Customer Service Representatives are available Monday through Friday from 7 a.m. to 6 p.m. or Saturday from 8 a.m. to 4 p.m. CT. Please have your credit card information available at the time of your order to cover your copay or coinsurance.

Patient Name _____ Member ID # _____ Birth Date _____

Allergies _____

Other Allergies _____

Please include any over-the-counter medications, vitamins, herbal supplements and/or health/disease states.

Medication Name	Prescription Number	Doctor Name	Doctor Phone Number

Prescription reorders with authorized refills are sent within three business days. There is no charge for standard shipping. Expedited shipping is available for an additional charge upon request. Orders cannot be shipped outside the United States.

Shipping

Name _____

Shipping Address _____

City _____ State _____ Zip _____

Phone _____

Billing Address **Same as shipping**

Name _____

Billing Address _____

City _____ State _____ Zip _____

Phone _____

Please note: As required by Minnesota State Law and in order to save you money, whenever possible this pharmacy will substitute an FDA-approved, less expensive, generic drug product, which is therapeutically equivalent to and safely interchangeable with the one prescribed by your doctor unless you object to this substitution. If you prefer a brand-name drug, you may be asked to pay a higher brand-name copay or the cost difference between the brand-name drug and the generic drug in addition to your copay.

Initial if you DO NOT want a generic equivalent drug _____

Payment (*Payment is required before shipping*)

Credit Card – Payment Method

I authorize the HealthPartners myMailRx Pharmacy to use my credit card for this order.

Check credit card type:

MasterCard® Visa®

American Express® Discover®

Card # _____ Expiration _____

Signature _____

Mail this form and payment to:
 HealthPartners myMailRx Pharmacy
 P.O. Box 44804
 Eden Prairie, MN 55344-2504

HealthPartners Pharmacy Refill Center is licensed for controlled substance prescriptions and non-controlled substance prescriptions in the following states: AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY. States that do not require out-of-state licensure to ship prescriptions to include: NY, MA.