MARTIN'S POINT®
US FAMILY HEALTH PLAN

TRICARE®

Mail form to:
Martin's Point Mail-Order Pharmacy
PO Box 9746
Portland, ME 04104
Phone: 1-800-707-9853

Please fill in current delivery address:

Name_____

Street _____

City_____State_____Zip _____

Daytime Telephone (____)_____

Please copy the following information from your ID card:

_____

Patient Name Date of Birth

Please list any allergies you may have.

_____

_____

_____

Please list any illnesses, medications you are currently taking, and any other comments you would like to make.

_____

_____

_____

To our valued mail-order pharmacy patients:

Please make sure the address you use is your mailing address. If you are expecting your medications in the mail and you may be away, please have a friend or neighbor check your mail for you.

Payment:

☐ Check or Money Order
Amount enclosed: $ _____

☐ MasterCard ☐ Visa ☐ Discover
Expiration Date (month/year): _____

Credit Card Number

Signature: _____

Please fill out the following:

NAME OF MEDICATION	FILL NOW	PLACE ON FILE

- Please allow 14 days for your medication to reach you.
- Some liquids, refrigerated items, and controlled substances cannot be mailed.
- Remember to allow your prescription eye and/or ear drops and any oral/nasal inhalers to adjust to room temperature before use.
- If NO authorized refills remain on your prescription, we will contact your provider and mail your prescriptions once authorization is obtained.
- Remember: payment is due at the time of service, so please enclose copayments. *You can find copayment amount by medication tier at **MartinsPoint.org/Pharmacy** or call Member Services at **1-888-674-8734.***
- Make checks payable to Martin's Point Pharmacy.