RxOutreach®
America's Nonprofit Pharmacy

www.rxoutreach.org

To enroll and order using this form, fax to 1-800-875-6591 or mail to 3171 Riverport Tech Center Dr., Maryland Heights, MO 63043.

Step 1: Complete your Membership Application

First Name: _____ MI: _____ Last Name: _____

Date of Birth:_____/_____ / _____ Email: _____ ❒ Opt in for emails

Street Address:_____

City:_____ State:_____ Zip: _____ Phone: (_____) _____

❒ Male ❒ Female ❒ Cell ❒ Home ❒ Opt in for text messages

MEDICAL CONDITION(s) Please check all that apply

☐ Heart Disease ☐ Alzheimer's ☐ Arthritis ☐ Diabetes ☐ Cancer ☐ Other

Medication allergies (if applicable): _____

_____

Medication(s) you are currently taking: _____

_____

ELIGIBILITY

Income Information:

Annual household income: $_____ Number of people in your household, including you:_____

You must sign this form before we can send your medication(s). *I attest that the information provided in this application is complete and accurate. This authorization or a copy shall be valid for 12 months from the date of the signature. I understand that Rx Outreach reserves the right to request income verification from me or refuse my application based on any misuse, abuse or illegal distribution of any product in this program. I will not seek reimbursement of any fee I pay to Rx Outreach from my health insurance, including Medicaid, Medicare or similar programs.*

Signature Required:_____ *Date:* _____/_____/_____

(If advocate/guardian signing on behalf of patient, please complete section below)

Event Code **788**

Patient's advocate / guardian contact (if applicable) _____

Relationship: _____ Phone: (_____) _____

Scan the code using your smartphone camera app or visit the website

rxoutreach.org/find-your-medication

TO ORDER CONTROLLED SUBSTANCES, YOU MUST ATTACH A COPY OF YOUR GOVERNMENT ISSUED PHOTO ID CARD.
To protect your safety, controlled substances and expedited shipping must be signed for upon delivery.
Controlled substances are identified by (CS) on the Medication List.

You can mail in the application and prescription or fax to 1-800-875-6591.
(Faxed prescriptions must come directly from the doctor's office)

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Step 2: Submit Your Prescription

Full Name: _____

D.O.B. _____ Phone (____) _____

☐ **Option A: Your Doctor will send prescription**

Ask your doctor to send your prescription to Rx Outreach:

1. By E-Script
2. By Phone: 1-888-796-1234
3. By Fax: 1-800-875-6591

☐ **Option B: I will mail in the Rx Outreach Membership Application and my prescription**

Rx Outreach, 3171 Riverport Tech Center Dr.
Maryland Heights, MO 63043

☐ **Option C: Rx Outreach requests transfer from another pharmacy.**

Please list the medications that you would like transferred from another pharmacy.

_____ Pharmacy Name

(____) _____ Phone Number

(____) _____ Fax Number

_____ Doctor's Name

Medication Name	Strength	Quantity Requested

☐ **Option D: Rx Outreach requests prescription from your doctor.**

Please list the medications that you would like requested from your doctor.

_____ Doctor's Name

(____) _____ Phone Number

(____) _____ Fax Number

Medication Name	Strength	Quantity Requested

Step 3: Choose a Payment Method

Pay by Credit, Debit Card, or FSA.

_____ Cardholder's Name

_____ Credit Card Number

_____ / _____ / _____ Expiration Date (MM/YY) CVV

I authorize Rx Outreach to charge this credit card for payment on my **first** order up to $ _____

OR

Pay by check or Money Order.

☐ I will make a payment by check or money order, and mail it to:

Rx Outreach
3171 Riverport Tech Center Dr.
Maryland Heights, MO 63043