# DENVER HEALTH PHARMACY RETAIL BY MAIL

## Pharmacy Retail by Mail Tips

- Prescriptions must be written for a 90-day supply by a Denver Health provider.
- Send the sign-up form and prescriptions to Denver Health Central Fill Pharmacy, 500 Quivas Street, Suite A, Denver, CO 80204.
- Please allow up to 7-10 work days for delivery.
- Credit card is the only method of payment.
  - o Medicaid Choice - a credit card is not needed, unless you wish to receive medications that are not a covered benefit by your drug plan.
  - o Call your health plan at the phone number on the back of your ID card to find out what drugs are not covered.
  - o All other plans must have a credit card on file.
- All orders are shipped by the U.S. Postal Service. You cannot tell from looking at the package that medications are inside.
- Controlled substances or specialty medications cannot be filled through this program. These must be picked up at any of the Denver Health Outpatient pharmacies.
- To refill Retail by Mail prescriptions
  - o Call the automated refill line 1-303-389-1390
  - o Visit https://mychart.denverhealth.org
  - o Use the MyChart Smartphone App

## Sign-Up Form

Please fill out this form to sign up for the Denver Health Pharmacy Retail by Mail program. This program can only be used for deliveries within the state of Colorado. By filling out this form you understand your address and contact information must be up-to-date. If medication is delivered to the wrong address because you did not update your address, your drug plan may not cover a new order to be shipped.

### PRIMARY PATIENT INFORMATION

Name: ____________________ Date of Birth: __________

Address: ______________________________

City, State, Zip: ____________________ Phone Number: __________

Email Address (so we can contact you when prescriptions have shipped and/or if any issues come up): ______________________________

☐ Please check box if this is a change of address

## INSURANCE INFORMATION

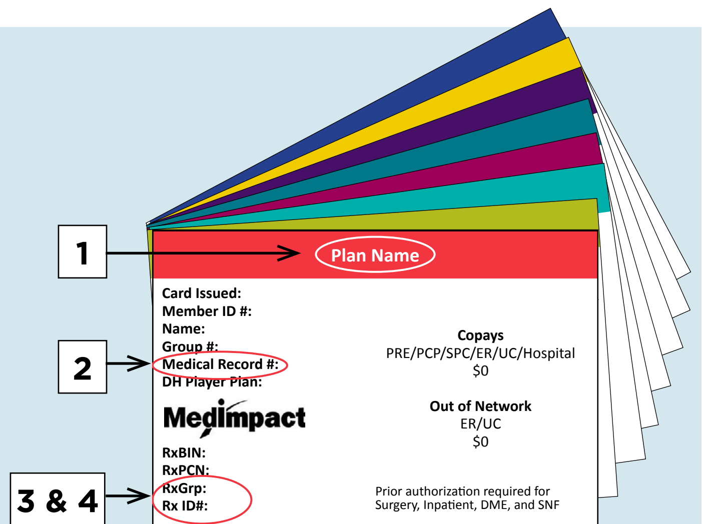
Please write down the insurance information on your card below:

1 Plan Name: ______________________

2 Medical Record # MRN: ______________ (if available)

3 RxGrp: ______________________

4 Rx ID#: ______________________




## FAMILY MEMBERS TO ALSO RECEIVE RETAIL BY MAIL*

If a family member's address is different from the Primary Patient, please contact the pharmacy at 303-602-2326.

Name: ______________________ Date of Birth: ______________

Rx ID#: ______________________ Rx Grp: DHM______________

Name: ______________________ Date of Birth: ______________

Rx ID#: ______________________ Rx Grp: DHM______________

Name: ______________________ Date of Birth: ______________

Rx ID#: ______________________ Rx Grp: DHM______________

*This portion is for you to write down your family member's information only if they are under 18 or you have legal rights to help with their care.

## PAYMENT INFORMATION

**I have enclosed _____ prescriptions.**

Orders with copayments or that are not covered by your insurance plan will not be sent without payment - Credit Card Only.

†Medicaid Choice members do not need to have a credit card on file, unless you wish to receive medications by mail that are not a covered benefit by your drug plan.

Credit Card Number*: ______________________________________

Credit Card Expiration: ______________ Circle one: Visa Mastercard Discover

Signature: ______________________ Date: ______________

Credit card will be kept on file unless declined by checking this box†: ☐

## Have questions or need to change your address?

Call Pharmacy Customer Service **303-602-2326** or toll free at **1-888-436-3442**

Monday-Friday, 9am-5pm