Cleveland Clinic
Pharmacy

Cleveland Clinic Pharmacies/Home Delivery Service: **Processing Form**

Date: _____/_____/_____

Patient Name: _____

Patient Date of Birth: ____/_____/____

Contact Phone No.: _____

Alternate Phone No.: _____

Primary Shipping Address:

Street: _____

City/State/Zip: _____

Email: _____

Patient Medical Record No.: _____

Prescription Insurance: _____

_____

_____

Patient Address:

Street: _____

City/State/Zip: _____

List prescriptions being filled (*name or Rx number*):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Is Generic OK? ❑ Yes ❑ No, Brand Name is requested

Drug Allergies (*please list*): _____

*If these are prescriptions from another pharmacy, please indicate the following:

Name and Phone No. of Pharmacy:

_____

_____

Rx Number(s) or Name(s) of Medications:

_____

_____

_____

Payment Method: At what amount would you like us to contact you before processing your order? $ _____

Employees Only:

Employee Name: _____ Prescription Insurance ID No.: _____

Employee ID Badge No.(*Required*):_____Badge Encoded No.:_____ (*6 digit number on back of ID badge*)

❑ **Payroll Deduction**

I understand that my badge is the property of the Cleveland Clinic Foundation and must be returned to the ID badge Department upon termination of employment or upon request by the Cleveland Clinic Foundation. I further understand that I will be responsible for all charges made with this badge and I hereby authorize those charges to be deducted from my paycheck. Charges made during a payroll period will be reflected as "Pharmacy" on the corresponding paycheck stub. Furthermore, I agree to protect this badge from unauthorized use and to pay Cleveland Clinic Pharmacies any outstanding balance upon termination of my employment or withdrawal from this program. I recognize that any unauthorized and/or illegal use of any badge is classified as a major infraction and will be grounds for disciplinary action in accordance with CCF Policy 121.

I have read the above information and agree to all of the above and authorize use of payroll deduction for the entire amount due.

Employee Signature: _____Date:___/___/___

***Note:** Any amount of $0-$49.99 will be deducted in 1 pay cycle. Any amount of $50.00 or more will be deducted over 6 pay cycles.

❑ **FSA Card (PayFlex):** Please also indicate an alternate form of payment should there be an insufficient balance. If PayFlex is your primary choice for payment, we will need a credit card to process any balance in excess of the PayFlex card.

FSA Card # _____

Exp. Date: _____

Signature: _____

❑ **Credit Card (Visa/Mastercard/Discover/AMEX)**

Credit Card # _____

Exp. Date: _____

Signature: _____

Phone: 216-448-4200
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Refills: myrefills.clevelandclinic.net

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