LDI
integrated pharmacy services

MAIL ORDER FORM

(314) 652-1121 or (866) 516-1121

www.LDIRx.com

ORDER FORM INSTRUCTIONS

1. Verify each Patient's Name, Telephone Number, Date of Birth are clearly written on each prescription.
2. Verify that the Physician's Name, Address and Phone Number are clearly written on each prescription.
3. Complete all sections of this order form; including front and back.
4. Fold the completed order form and place it along with the original prescription(s) in an envelope.
5. Enclose check, money order or credit card information (orders will not be mailed until payment is received).

I. PATIENT INFORMATION

PATIENT ONE

Member ID

Date of Birth M M – D D – Y Y Y Y

Gender ☐ Female ☐ Male

Patient Last Name

Patient First Name

Phone Number – –

Alternate Phone Number – –

Email Address

PATIENT TWO (If no additional patient, skip to **II. PRESCRIPTION INFORMATION** below.)

Member ID

Date of Birth M M – D D – Y Y Y Y

Gender ☐ Female ☐ Male

Patient Last Name

Patient First Name

Phone Number – –

Alternate Phone Number – –

Email Address

II. PRESCRIPTION INFORMATION - If additional space is required, use COMMENTS area on back of page.

PATIENT ONE

New	Refill	Medication Name & Strength	Rx Number	Qty	Days Supply	Rx Enclosed

PATIENT TWO

New	Refill	Medication Name & Strength	Rx Number	Qty	Days Supply	Rx Enclosed

III. SHIPPING ADDRESS - Allow 4-7 Business Days for Mailing After Order Has Been Processed. (Excluding Weekends & Holidays)

☐ Check if Shipping Address is the same as your Billing Address.

Address Line 1

Address Line 2

City

State

Postal Code –

IV. PHYSICIAN, ALLERGIES, OTHER HEALTH CONDITIONS

Physician 1 Last Name

Phone Number ___ – ___ – ____

Physician 2 Last Name

Phone Number ___ – ___ – ____

Allergies (Please circle any/all that apply.):
Codeine Sulfa Penicillin Tetracycline Cephalosporin Erythromycin Other _____

Health Conditions (Please circle any/all that apply.):
Arthritis Asthma Diabetes Thyroid Glaucoma Heart Condition High Blood Pressure
Other _____

V. BILLING ADDRESS

☐ Check if Billing Address is the same as your Shipping Address.

Address Line 1

Address Line 2

City

State

Postal Code ___ – ____

VI. METHOD OF PAYMENT - No Order will be Mailed until Payment has been Received.

☐ Check / Money Order

Amount Enclosed
$ ____ . __

Please make checks payable to LDI Pharmacy Services.

☐ Credit / Debit Card ☐ FSA Card

Credit Card

Expiration Date MM YYYY

CVV2 Code

☐ Charge this Order Only
☐ Charge Future Orders

NAME AS IT APPEARS ON CREDIT CARD

X AUTHORIZED SIGNATURE

☐ Check by Phone ($0.50 fee)

Checking Account Number

Routing Number

Check Number

VII. SIGNATURE - Signature is Required to Process Order.

I authorize the release of any medical information required to process this claim(s).

X AUTHORIZED SIGNATURE

__/__/__
Date of Signature

☐ Dispense generics as permitted by law.
☐ I request brand name only.
☐ I request **Non-Child Resistant Caps** on all medications.

COMMENTS OR SPECIAL INSTRUCTIONS

PHARMACY CONSULTATION

☐ ***Please check here if you have questions regarding your medication and would like a pharmacist to contact you.***

Mail Completed Order form, Original Prescriptions and Payment to:
LDI Integrated Pharmacy Services, 701 Emerson Rd., Suite 301 Creve Coeur, MO 63141