Mail Order Form

integrated pharmacy services

Questions? Call (866) 516-1121
701 Emerson Road, Suite 301
Creve Coeur, Missouri 63141
www.LDIRx.com

Instructions

LDI Home Advantage

1. Verify that each Patient's Name, Telephone Number and 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 form and place it along with the original prescription(s) in an envelope.
4. Enclose check, money order or credit card information (orders will not be mailed until payment is received).

Patient Information

Patient One

Last Name | First Name

Member ID | Date of Birth (MM-DD-YYYY) | Email

Phone Number (- - -) | Alternate Phone Number (- - -) | Sex: Male ☐ Female ☐

Patient Two (If there is no additional patient, skip to Prescription Information)

Last Name | First Name

Member ID | Date of Birth (MM-DD-YYYY) | Email

Phone Number (- - -) | Alternate Phone Number (- - -) | Sex: Male ☐ Female ☐

Prescription Information

Please enclose your new prescription(s) in the envelope. To refill existing prescriptions, fill out the information below.

Patient One

Rx Number	Medication Name and Strength	Quantity	Days Supply

Patient Two

Rx Number	Medication Name and Strength	Quantity	Days Supply

Shipping Address (Allow 4-7 business days for mailing after order has been processed)

Address

City | State | Zip Code (-)

Additional Information

LDI
integrated pharmacy services

Questions? Call (866) 516-1121
701 Emerson Road, Suite 301
Creve Coeur, Missouri 63141
www.LDIRx.com

Physician Information

Physician Last Name

Physician Phone Number

Physician Last Name

Physician Phone Number

Allergies and Other Health Conditions

Please list any allergies.

Please list any health conditions.

Billing Address

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

Address

City

State

Zip Code

Method of Payment (No order will be mailed until payment has been received)

Credit / Debit Card

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS ☐ FSA CARD

Card Number

Expiration Date MM-YYYY

CVV2 Code

Name (As it appears on card)

Authorized Signature

X

Check by Phone ($0.50 fee)

Checking Account Number

Routing Number

Check Number

Check / Money Order

Amount Enclosed

Please make checks payable to LDI Pharmacy Services.

Signature (Signature is required to process order)

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

X

Date of Signature MM-DD-YYYY

☐ Dispense generics as permitted by law. ☐ I request brand name only. ☐ I request non-child resistant caps on all medication.

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

Comments or Special Instructions

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