



Member Information – Please use black or blue ink and CAPITAL LETTERS only

First Name			Last Name			MI	Suffix
Member ID				Plan Name			
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Number of New Prescriptions	<input type="text"/>	Group Number			
Mobile Phone (Include area code)* <input type="checkbox"/> Set as Preferred Phone				Home Phone (Include area code)* <input type="checkbox"/> Set as Preferred Phone			
Shipping Address Line 1 <input type="checkbox"/> Use this address for this order only				Billing Address Line 1 <input type="checkbox"/> Check if same as Shipping Address			
Shipping Address Line 2				Billing Address Line 2			
City	State	Zip Code	City	State	Zip Code		
Email Address (Email used for order status updates)							

How to Contact Me

I want to receive automated phone calls, text messages or email to help me manage my medications.
 My preferred method of getting notices is:

Automated Phone Call* Text Message* Email*

*When you provide these numbers, we have your permission to contact you at these numbers about your Birdi account. Your consent allows us to use text messaging, prerecorded voice messages and automated dialing technology for informational service calls, but not for telemarketing or sales calls. Message and data rates may apply. You may change these preferences or opt-out at any time by signing in to www.BirdiRx.com and updating your notifications preferences.

Health Information

Allergies	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracyclines
<input type="checkbox"/> None	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> Quinolones	<input type="checkbox"/> Other _____
<input type="checkbox"/> Amoxil/Ampicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Sulfa	_____
Health Conditions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> None	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pregnancy	_____

Physician Information

Physician Last Name	Physician First Name
Physician Phone (Include area code)	Physician Fax (Include area code)

Payment Information – Do not send cash

For fastest service, pay by credit or debit card. We accept VISA®, Mastercard®, Discover®, or American Express®. If you need to pay by check or money order, please call to speak with a representative.

Cardholder Last Name

Cardholder First Name

Charge my payment method on file (Returning Customers)

Charge my NEW credit card: Visa® Mastercard® Discover® American Express®

Ship Expedited Delivery

(Add \$25 to my prescription amount)

Credit Card Number

Expiration Date

Security Code

Standard shipping is free. Your order can take up to 10 days for delivery from the date we receive your order. You may choose expedited delivery for an additional \$25 by checking the box above. Expedited delivery orders can only be sent to a street address, not a PO Box. Expedited delivery will reduce the shipping time 1–2 days. Processing time may take 3–5 business days from the time **Birdi** receives your prescription.

I authorize **Birdi** to charge my credit card for any co-payment, coinsurance, deductible, or any other amount owed on my prescriptions, including any applicable expedited delivery charges.

X

Cardholder's Signature

Date

Check this box if you DO NOT want us to use this payment method for future orders or balance due.

You can call **Birdi** to update this information at any time or you can update your payment preferences by signing in to your account at www.BirdiRx.com.

Authorizations

By returning this form to **Birdi** you verify that information is correct, that the prescriptions enclosed are for eligible participants, and you consent to the release and use of the patient's health information to the patient's health plan(s) and health care providers/agents for health benefit management. **Birdi's** use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources, such as medical providers, shall be in accordance with federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

X

Signature

Date

Mail this completed order form, with your prescription and payment information, to:

Birdi, PO BOX 8004, Novi, Michigan 48376-8004

Ask your doctor to send your prescription electronically to Birdi or to fax it to us at: **1-877-395-4836**

****Please note, we can only accept electronic prescriptions and faxes from your health care provider.**