FredMeyer · City Market Food & Pharmacy · Dillons · fry's · Kroger · King Soopers · Gerbes · QFC · Ralphs · Smith's · PPS Postal Prescription Services

THE KROGER CO. FAMILY OF STORES

How to Order New Prescriptions

If you take the same medication for months at a time. You'll often find that getting your prescription through the mail will be easier and less expensive than getting them from your local pharmacy. **However, prescription mail order services should not be used for medications you need immediately (sooner than two weeks.)**

For maintenance medications you need to start taking right away: you may ask your doctor for two prescriptions. One for a small supply to be filled at your local pharmacy for immediate use, and one for the mail service pharmacy. Remember to ask the doctor to write the mail order prescription for the maximum quantity your plan allows and for one year of refills (if the law allows). Then mail them to Postal Prescription Services following these easy steps:

1. On the front of each new prescription, *print clearly*:
   - The member's name and relationship to the primary covered person (e.g., self, spouse, child).
   - The member's ID number from the primary covered person's plan.
2. Be sure the prescribing doctor's name is clearly indicated.
3. Complete the order form including payment information.

4. Provide a street address for delivery. Some medications, such as narcotics and drugs requiring refrigeration are restricted from delivery to a post office box.

5. Send your prescriptions, completed order form, and a co-pay in the envelope provided. A new order form and envelope will be returned with each Postal Prescription Service delivery.

How to Order Refills

If your doctor has prescribed a refill, then Postal Prescription Service will send you a refill slip with your medication order. When you need the refill, just detach the refill slip and mail it back with your completed order form and co-pay.

If you cannot locate your refill slip, list the prescription numbers and the names of the medication on the order form. The prescription number is located in the upper left-hand corner of the label on your medication container.

Refills may also be ordered by phone by calling the toll-free number listed in this brochure. Please remember to have your credit card information and the prescription numbers you would like to order ready. You can also order refills through our website at www.ppsrx.com.

Refills too soon?

Refer to the reorder date on your refill slip. For your safety, refill orders placed too early cannot be filled and may be returned.

Generic Drugs

Generic medications will be substituted for brand-name medications when available and allowed by the prescribing physician. PPS utilizes only those generic medications rated highest by the FDA.

Service & Safety

Postal Prescription Services' registered Pharmacists review each prescription for accuracy before dispensing, and perform checks to assure all prescriptions are dispensed correctly.

We maintain computerized patient profiles to prevent adverse reactions with other prescriptions you are receiving from Postal Prescription Services. Should any questions arise regarding potential adverse reactions, our pharmacist will contact your doctor or you, before dispensing the medication.

Delivery Time

Please allow two weeks for delivery from the date you mail your order. Your order will be delivered to the address you requested by United Parcel Services or first class US mail. In case of emergency, prescriptions can be shipped overnight *for an additional charge to you.* Postal Prescription Service is open for business Monday through Friday 6:00 a.m. to 6:00 p.m. and Saturday 9:00 a.m. to 2:00 p.m., Pacific Time.

PPS®

POSTAL PRESCRIPTION SERVICES®

To Order Prescriptions By Mail, Use the Convenient Order Form Enclosed.

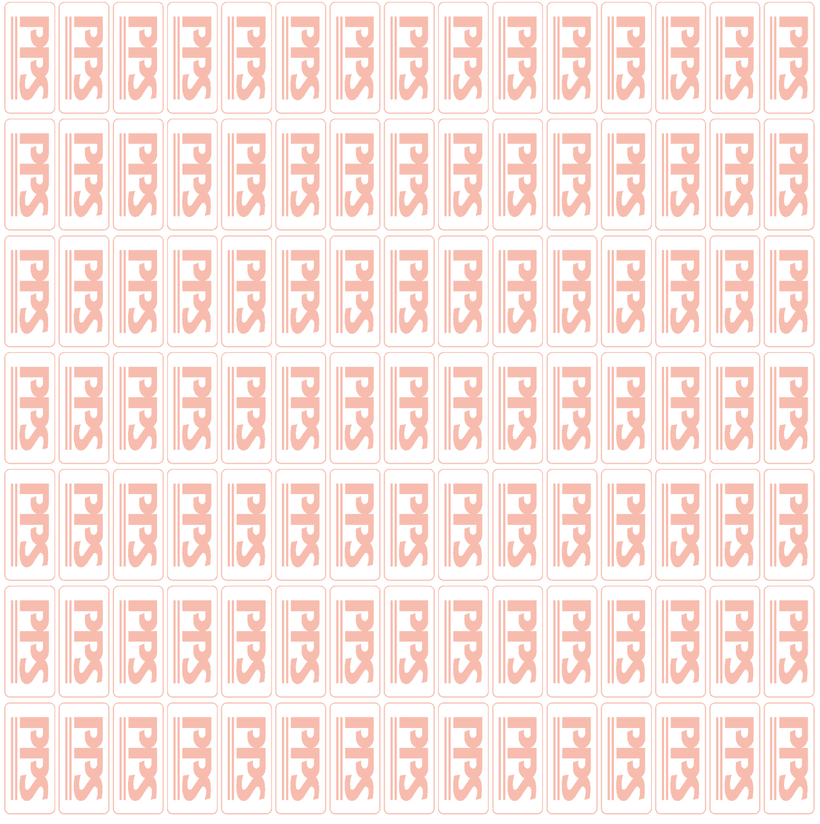
To Order by Phone:
1-800-552-6694
In Portland, Oregon:
(503) 797-2100

Visit Our Website:
www.ppsrx.com

Postage Required
Post Office will not deliver without proper postage.

FROM

PPS PRESCRIPTION SERVICES
PO BOX 2718
PORTLAND OR 97208-2718



Tear here, insert order form in envelope and seal.

PPS Postal Prescription Services

Date I mailed my order _____ Co-pay Amount Enclosed $_____

Tear here, and keep this stub for your records.

Questions?
call: 1-800-552-6694
in Portland, Oregon:
(503) 797-2100

Health Care Plan Information

Health Care Plan

Employer Name (if applicable)

Insured's I.D. Number

Insured's Name

If possible, please enclose a copy of your insurance card when placing your initial order or when changing insurance.

Patient Information

Primary

Last Name First Name M.I.

__/__/__ Date of Birth ☐ ✔ Male ☐ ✔ Female

Doctor/Prescriber name and Phone No.

Spouse

Last Name First Name M.I.

__/__/__ Date of Birth ☐ ✔ Male ☐ ✔ Female

Doctor/Prescriber name and Phone No.

Dependent

Last Name First Name M.I.

__/__/__ Date of Birth ☐ ✔ Male ☐ ✔ Female

Doctor/Prescriber name and Phone No.

✔ Drug Allergies / Health Condition

☐ NONE ☐ CODEINE ☐ PENICILLIN ☐ SULFA
☐ ASPIRIN ☐ OTHER _____

☐ ASTHMA ☐ DIABETES ☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE ☐ HYPERLIPIDEMIA
☐ OTHER _____

☐ NONE ☐ CODEINE ☐ PENICILLIN ☐ SULFA
☐ ASPIRIN ☐ OTHER _____

☐ ASTHMA ☐ DIABETES ☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE ☐ HYPERLIPIDEMIA
☐ OTHER _____

☐ NONE ☐ CODEINE ☐ PENICILLIN ☐ SULFA
☐ ASPIRIN ☐ OTHER _____

☐ ASTHMA ☐ DIABETES ☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE ☐ HYPERLIPIDEMIA
☐ OTHER _____

Ship To This Address

Last Name First Name Middle Initial

Street Address

City State Zip Code

Home Phone ( ) _____

Day Phone ( ) _____

Thank You.
We appreciate your business!

- Order *prescription refills* or transfers here by enclosing refill slips or filling out this section →
- ✔ For *new prescriptions*, enclose the prescription in the envelope provided and check here. ☐

Qty.	Prescription No.	Name of Medication	Strength	Pharmacy Name	Pharmacy Phone	Doctor's Name & Phone	Price or Co-Pay
						Total: $	

Non-Safety Cap Request Information:

Federal law requires that your prescription shall be dispensed in a container with a child resistant or safety cap unless you request otherwise. If you would like your prescription with an "easy-open" lid please sign below. I do not want safety caps:

X _____
Patient's Signature Here Date

Method of Payment:

❑ Check ❑ Money Order ❑ Visa/MasterCard ❑ Discover ❑ Am. Express

_____ _____ _____ _____ _____
Credit Card Number Exp. Date

X _____
Cardholder's Signature

Make check or money order payable to:
PPS