

EnvisionMail is a mail order pharmacy. We offer home delivery of monthly medications with no shipping or handling fees for standard delivery. You may receive up to a 90-day supply of most medications delivered right to your door.

To obtain your mail order prescriptions from EnvisionMail, you need to create an account using one of the three following methods:

1. Complete this enrollment form and mail it to EnvisionMail at:  
**7835 Freedom Ave NW, North Canton, OH 44720**; Or
2. Enroll online at **envisionpharmacies.com**. You will need your prescription ID to register for an account; Or
3. Enroll via telephone at **866-909-5170** or **TTY 711** (Monday–Friday 8:00 a.m.–10:00 p.m., and Saturday 8:30 a.m.–4:30 p.m.)

Once we begin filling your prescriptions, you may order refills by calling **866-909-5170** (or **711** for TTY users). Representatives are available Monday–Friday 8:00 a.m.–10:00 p.m., and Saturday 8:30 a.m.–4:30 p.m. For your convenience, our automated system is available 24 hours a day, seven days a week. You may also order refills online at **envisionpharmacies.com**.

### MEMBER INFORMATION

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Member Identification Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: ☐ M ☐ F Email: \_\_\_\_\_

Drug Allergies: ☐ No Known Allergies ☐ Erythromycin ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Sulfa  
☐ Other: \_\_\_\_\_

### PAYMENT INFORMATION

We accept the following payment methods:

- Check: (personal check, bank check, and check by phone).
- Credit Card: (Visa, MasterCard, Discover, Amex)
- Money Order
- We are unable to accept Cash payments.

Please update payment information online at **envisionpharmacies.com** or by telephone at **866-909-5170** or **711** for TTY users, (Monday–Friday 8:00 a.m.–10:00 p.m., and Saturday 8:30 a.m.–4:30 p.m.).

## SPECIAL HANDLING

Please initial this line if you do **not** want child-proof caps mailed to your household. We will send snap caps or easy-off lids with your medications if you initial this line.

**Generics:** EnvisionMail will automatically dispense the generic drug unless your prescriber writes “DAW” (dispense as written) on the prescription and the brand name drug is medically necessary. Brand name drugs typically require you to pay a higher copayment.

## USE &amp; DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time.

## DESIGNATION OF AUTHORIZED PARTY

For the Use and Disclosure of Protected Health Information

The patient (“Patient”) signing this Designation of Authorized Party (“Authorization”) authorizes EnvisionPharmacies to disclose Patient health information (“Patient Information”) to the following person, as “Authorized Party”:

\_\_\_\_\_  
Name Of Authorized Party

This Authorization is to allow EnvisionPharmacies to disclose Patient Information to enable the Authorized Party to help and assist the Patient with the Patient’s EnvisionPharmacies prescriptions and payment matters on a standing basis, for as long as this Authorization is in effect

EnvisionPharmacies cannot control whether Patient Information may be subsequently disclosed as a result of this Authorization. Such Patient Information, in the Authorized Party’s or someone else’s hands, may not be protected by the HIPAA Privacy Rule, though it may be protected under other laws.

EnvisionPharmacies does not condition Treatment or Payment based on this Authorization. The Patient has the right to request how Patient Information may have been disclosed under this Authorization. The Patient has the right to have and keep a signed copy of this Authorization. A hard or electronic copy of the original of this Authorization shall be treated as if it were the original.

This Authorization shall expire One (1) Year from the date appearing below. However, the Patient may revoke this Authorization at any time in writing to EnvisionPharmacies, at Privacy Officer, EnvisionPharmacies, 7835 Freedom Avenue NW, North Canton, OH 44720. EnvisionPharmacies shall honor any such written request, except where EnvisionPharmacies may have taken action in good faith reliance on this Authorization.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient ID:

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date