

# Right Source<sup>SM</sup>

## REGISTRATION & PRESCRIPTION ORDER FORM

### MEMBER INFORMATION

Member ID Number: \_\_\_\_\_

*found on Humana ID card*

Name: \_\_\_\_\_

*First*

*Last*

E-mail Address: \_\_\_\_\_

Date of Birth (MM/DD/YYYY)

Male

Female

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Daytime Phone: ( ) \_\_\_\_\_

Evening Phone: ( ) \_\_\_\_\_

Dr. Name: \_\_\_\_\_

Dr. Phone: \_\_\_\_\_

#### ALLERGIES:

No Known

32 – Codeine

70 – Penicillin

87 – Sulfa

93 – Tetracycline

Other: \_\_\_\_\_

#### HEALTH CONDITIONS:

No Known

200 – Diabetes

300 – Hypertension

400 – Heart Disease

500 – Glaucoma

600 – Stomach Disorders

700 – Thyroid Disease

800 – Arthritis

Other: \_\_\_\_\_

### DEPENDENT INFORMATION

Member ID Number: \_\_\_\_\_

*found on Humana ID card*

Name: \_\_\_\_\_

*First*

*Last*

E-mail Address: \_\_\_\_\_

Date of Birth (MM/DD/YYYY)

Male

Female

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Daytime Phone: ( ) \_\_\_\_\_

Evening Phone: ( ) \_\_\_\_\_

Dr. Name: \_\_\_\_\_

Dr. Phone: \_\_\_\_\_

#### ALLERGIES:

No Known

32 – Codeine

70 – Penicillin

87 – Sulfa

93 – Tetracycline

Other: \_\_\_\_\_

#### HEALTH CONDITIONS:

No Known

200 – Diabetes

300 – Hypertension

400 – Heart Disease

500 – Glaucoma

600 – Stomach Disorders

700 – Thyroid Disease

800 – Arthritis

Other: \_\_\_\_\_

Please copy registration form for additional dependents.

#### Mail form, payment, and prescriptions to:

RIGHTSOURCE

P.O. Box 29200

Phoenix, AZ 85038-9200

\*Please refer to your benefit materials at

[www.humana.com](http://www.humana.com) for mail-order copayment information

VISA / MasterCard / HumanaAccess<sup>SM</sup> Card / Discover /  
American Express (*Please circle the card being used*)

Credit card number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

**Please note:** By submitting this form, you have authorized release of all information to RightSource (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

*Thank you for your order. Please allow two weeks from the postmark date on your order form.*