

REFILLS BY MAIL

You now get your prescription refills without having to worry about driving to the hospital, the price of gas, standing in line at the pharmacy, or finding someone else to pick them up for you.

Once you sign up for the mail-out refill program all of your refills will be mailed to you. Most medications dispensed by your Rapid City IHS Pharmacy can be mailed, however *controlled Substances (narcotics) will not be mailed. Also, some refrigerated medications cannot be mailed to Post Office Boxes. This prescription by mail service is available only to patients who reside within our service area, which is the following South Dakota counties: Pennington, Meade, Custer, Butte, and Lawrence.*

HOW DO I GET SIGNED UP TO RECEIVE MY REFILLS BY MAIL?

There are a few rules to the Mail-Out program that must be followed to assure the program works smoothly and effectively for everyone involved....you the patient, the pharmacy department, the hospital, the post office and your health insurance prescription plan.

Here is WHAT YOU MUST DO to use the Prescription Mail-Out Service:

- 1. COMPLETE the Refills by Mail Enrollment Form and ALWAYS MAKE SURE your mailing address and telephone information are kept CURRENT with the Patient Registration and Pharmacy Departments.**
- 2. ALWAYS TALK to the pharmacist the day that you see your medical provider even if you do not need medications on that day. (It is also important to let your pharmacist know if you don't want to wait for your chronic medication refills and want them mailed to you instead.)**
- 3. CHECK your mail daily on the days following your refill request to safeguard against loss and exposure to weather extremes.**
- 4. PLAN AHEAD! It can take up to 1 week to receive your prescription in the mail, so order your prescription refills about 7 days before you will be out of medicine.**
- 5. Use the Automated Telephone Refill System (355-2240) to request your medication refills and ALWAYS FOLLOW the Prescription Mail-Out Program instructions to assure timely delivery.**

PLEASE PRINT

Name _____

Chart Number _____

Address _____ City _____ State _____ Zip Code _____

Day Phone # _____ Night Phone # _____ Cell Phone # _____

My signature indicates my agreement to follow the requirements of the Prescription Mail-Out Program and provides written verification of receipt of all mailed medications as required by my prescription drug insurance plan unless contested within 5 days of my refill request.

Signature _____

.Pharmacy Staff Member _____