

# www.GenericMedicineProgram.com Order Form

"Patient Assistance Program Where EVERYONE Qualifies!"

See Website for Covered Medicines

**FREE ENROLLMENT! NO HIDDEN FEES! Fax Order To 1-573-996-5566 or Call 1-573-996-3333**

Generic Medicine Program is an easy and affordable way for people of all ages to get medicines they need. Everyone qualifies and enrollment is free to families and individuals of all ages nationwide, whether you have insurance or not. In some cases this program will be less expensive than your prescription drug co-pay. Through this program, you can get more than 1500 generic medications that treat a wide range of conditions including diabetes, asthma, heart disease, and depression. Our program ensures low-cost, predictable pharmaceutical services for those taking maintenance drugs.

**Save up to 95%!  
OR MORE!**

**Pay Only \$3.75 or LESS for a Month Supply for Any Medicine on Program List A**  
**ARE YOU MISSING YOUR CHANCE TO SAVE MONEY?**

(Our minimum order requirement is 90 tablets/capsules to maximize savings for you)

Please Print Clearly

New Prescription Order    Refill Order   **Do You Want to Be Contacted For Refills?**    Yes    No

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Email Address \_\_\_\_\_ @ \_\_\_\_\_

Today's Date

How did you hear about us?

\_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address (Street number / street name / apartment number / P.O. Box number)

\_\_\_\_\_

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Address Continued (Street number / street name / apartment number / P.O. Box number)

\_\_\_\_\_

Social Security Number

M  F  Diabetic?  Yes  No  
 On Medicare?  Yes  No

City \_\_\_\_\_ State \_\_\_\_\_ Postal Code \_\_\_\_\_

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_    \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Phone number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Please attach additional sheet if you need to list more doctors.

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ DEA # \_\_\_\_\_

**Our Minimum Order Requirement is 90 tablets/capsules to Maximize Savings for You.**  
**Order More to Save More!**

	NAME OF MEDICATION	STRENGTH	QUANTITY	PRICE
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____

**Send This Completed Order Form, Payment and Prescription(s)**  
**By Fax (24/7) 1-573-996-5566**  
**OR Mail to: Generic Medicine Program**  
**P.O. Box 125, Doniphan, Mo. Postal Code 63935-0125**

See Website for Covered Medicines

Shipping & Handling Charge Per Order

Enrollment Fee **FREE**  
 Total Amount Due \_\_\_\_\_

**Other Medication You Are Currently Taking**

Please list other medications that you are currently taking.

**Medical History**

Please list present illness: (ongoing) eg. Diabetes, Heart Disease, Osteoporosis, etc. (attach separate sheet if required)

**Drug Allergy Information**

Do you have any drug allergies or medical conditions we should be aware of? If so, what? (attach additional sheet of paper if necessary)

**Payment Information**

Visa    Discover    Money Order or Check  
 American Express    MasterCard  
(Payable to Generic Medicine Program) Personal checks may take up to 7 days to process.

Billing Address Same as Shipping?  Yes  No

Cardholder's Name \_\_\_\_\_

Cardholder's Address \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Exp Date \_\_\_\_\_

Security Code (Located on back of card) \_\_\_\_\_

**X**

Cardholder's Signature \_\_\_\_\_

**Pay With Bank Account**

Bank Routing Number (9 Digits) \_\_\_\_\_

Bank Account Number (up to 17 Digits)  
**Do Not Enter a Check Number**

Account Holder's Full Name \_\_\_\_\_

Driver's License Number/State \_\_\_\_\_

Please Make Copies of This Form if More Medicines Are Needed. Check Website For the Latest Covered Drug List

I authorize Generic Medicine Program and its filling pharmacies and/or agents, to process total amount due for this order debit entries from my bank account or credit card as provided. This authority will remain in effect until I give reasonable notification to terminate this authorization. I understand that there will be a fee automatically charged to my account for any insufficient funds (NSF) transactions. User agrees to defend, indemnify, and hold harmless the Generic Medicine Program and its respective officers, employees, and agents from and against all claims and expenses, including attorneys' fees, arising out of the use of this service.

**X**

Signature (Required) \_\_\_\_\_

**BY MY SIGNATURE, I AGREE TO THE TERMS AND CONDITIONS OF USING MY BANK ACCOUNT AS A PAYMENT METHOD, WHICH ARE STATED ON WWW.GENERICMEDICINEPROGRAM.COM, AND AUTHORIZE GENERICMEDICINEPROGRAM.COM OR ITS AGENT TO DEBIT MY BANK ACCOUNT FOR PURCHASES MADE ON OR THRU GENERICMEDICINEPROGRAM.COM/MED-EX DIRECT.**