



Member Information – Please use black or blue ink and CAPITAL LETTERS only

Form with fields for Member Information: First Name, Last Name, MI, Suffix, Member ID, Plan Name, Date of Birth, Gender, Number of New Prescriptions, Group Number, Mobile Phone, Home Phone, Shipping Address, Billing Address, City, State, Zip Code, Email Address.

How to Contact Me

I want to receive automated phone calls, text messages or email to help me manage my medications. My preferred method of getting notices is: [] Automated Phone Call* [] Text Message* [] Email**

*When you provide these numbers, we have your permission to contact you at these numbers about your Birdi account. Your consent allows us to use text messaging, prerecorded voice messages and automated dialing technology for informational service calls, but not for telemarketing or sales calls. Message and data rates may apply. You may change these preferences or opt-out at any time by signing in to www.medimpact.com.

** By providing your email address you (1) consent to us sending you communications by email about your Birdi account or medication that may contain protected health information, and (2) acknowledge and accept that email communications are not secure and there is a risk that they may be intercepted or viewed by unauthorized parties.

Health Information

Health Information section with checkboxes for Allergies (Aspirin, Erythromycin, Penicillin, Tetracyclines, etc.) and Health Conditions (Asthma, Glaucoma, High Cholesterol, etc.).

Medicine List section: Please list any prescription and over-the-counter medicines you are currently taking. Includes three blank lines for text entry.



Payment Information – Do not send cash

For fastest service, pay by credit or debit card. We accept VISA®, Mastercard®, Discover®, or American Express®. If you need to pay by check or money order, please call to speak with a representative.

Cardholder Last Name	Cardholder First Name
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<input type="checkbox"/> Charge my payment method on file (Returning Customers) <input type="checkbox"/> Charge my NEW credit card: <input type="checkbox"/> Visa® <input type="checkbox"/> Mastercard® <input type="checkbox"/> Discover® <input type="checkbox"/> American Express®	<input type="checkbox"/> Ship Expedited Delivery (Add \$25 to my prescription amount)
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Credit Card Number	Expiration Date	Security Code
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Standard shipping is free. Your order can take up to 10 days for delivery from the date we receive your order. You may choose expedited delivery for an additional \$25 by checking the box above. Expedited delivery orders can only be sent to a street address, not a PO Box. Expedited delivery will reduce the shipping time 1–2 days. Processing time may take 3–5 business days from the time **Birdi™** receives your prescription.

I authorize **Birdi™** to charge my credit card for any copayment, coinsurance, deductible, or any other amount owed on my prescriptions, including any applicable expedited delivery charges.

X _____ Cardholder's Signature	Date
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Check this box if you DO NOT want us to use this payment method for future orders or balance due. You can call **Birdi™** to update this information at any time or you can update your payment preferences by signing in to your account at www.medimpact.com.

Authorizations

Check here to request Easy Open Caps. 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 an Easy Open Cap, please check the box.

By returning this form to **Birdi™**, you verify that information is correct, that the prescriptions enclosed are for eligible participants, and you consent to the release and use of the patient's health information to the patient's health plan(s) and health care providers/agents for health benefit management. **Birdi™**'s use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources, such as medical providers, shall be in accordance with federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

X _____ Signature	Date
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Mail this completed order form, with your prescription and payment information, to:

Birdi™, PO BOX 51580, Phoenix, AZ 85076-1580

Ask your doctor to send your prescription electronically to Birdi™ or to fax it to us at: 1-888-783-1773.
**Please note, we can only accept electronic prescriptions and faxes from your health care provider.

This letter may contain confidential individually identifiable health information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other statutes.

DISCRIMINATION IS AGAINST THE LAW

Doctors HealthCare Plans, Inc. complies with applicable civil rights laws and does not discriminate or exclude individuals on the basis of race, color, national origin, age disability, sex, sexual orientation, pregnancy, gender, gender identity, or religion.

Doctors HealthCare Plans, Inc. provides: (1) free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and, (2) free language services to individuals whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your ID Card. If you believe that Doctors HealthCare Plans, Inc., has failed to provide these services or discriminated in any way, you can file a grievance with:

Doctors HealthCare Plans, Inc., Attention: Member Services Department, 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134 or call (786) 460-3427 or (833) 342-7463, TTY:711; 7 days a week; 8AM to 8PM EST.

You can file a grievance by calling, in person or by mail. If you need help filing a grievance, our Member Services Representatives are available to help you at the number listed above. You can also file a civil rights complaint electronically through the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or call (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

MULTI-LANGUAGE INTERPRETER SERVICE

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (833) 342-7463 (TTY:711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (833) 342-7463 (TTY:711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务,帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务,请致电 (833) 342-7463 (TTY:711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問,為此我們提供免費的翻譯服務。如需翻譯服務,請致電 (833) 342-7463 (TTY:711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamat. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (833) 342-7463 (TTY:711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (833) 342-7463 (TTY:711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi (833) 342-7463 (TTY:711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (833) 342-7463 (TTY:711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (833) 342-7463 (TTY:711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (833) 342-7463 (TTY:711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (833) 342-7463 (TTY:711). سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (833) 342-7463 (TTY:711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (833) 342-7463 (TTY:711). Irá encontrar alguém que fale idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (833) 342-7463 (TTY:711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (833) 342-7463 (TTY:711). Ta usługa jest bezpłatna.

Hindi: हमारे सवा य या दवा की योजना के बारे में आपके किसी भी परन के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया परापत करने के लिए, बस हमों (833) 342-7463 (TTY:711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、(833) 342-7463 (TTY:711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。