

HomeStar Mail Order Pharmacy

If you have any questions concerning HomeStar Mail Order services, please call (610) 628-8900 or Toll Free at 1-855-649-MEDS

Cardholder Name _____	
Mailing Address _____	
Home Phone No. _____	Cell Phone No. _____
E-Mail Address _____	
PTRX Cardholder Id No. _____	
Secondary Insurance (If Applicable):	
Carrier _____	Carrier Phone No. _____
Id Number _____	Group No. _____
Dependent And Medical Information: (Complete where applicable)	
Member _____	
_____	_____
_____	_____
Allergies: _____	
Health Conditions: _____	
Spouse _____	
_____	_____
_____	_____
Allergies: _____	
Health Conditions: _____	
Dependent _____	
_____	_____
_____	_____
Allergies: _____	
Health Conditions: _____	
Dependent _____	
_____	_____
_____	_____
Allergies: _____	
Health Conditions: _____	
Continue On Other Side If Necessary	
Number of Rx's to be filled _____	Number of Rx's to be placed on hold _____
Billing Address (If different from above) _____	
Payment Method	
<input type="checkbox"/> Payroll Deduction - Badge Number: _____ (5 digit # after the * on your Badge)	
<input type="checkbox"/> Credit Card - (Circle One) Visa MasterCard Discover	
Card Number _____	Ccv# _____ Exp _____
Signature _____	

Please complete form and forward to:

HomeStar Mail Order Pharmacy, 1736 Hamilton Street, Allentown, PA 18104

Fax: 610-628-8901



Dependent And Medical Information: (Complete where applicable)

Dependent _____ Allergies: _____ Health Conditions: _____	First Name / Middle Initial / Last Name _____	Date of Birth _____	Gender _____
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