Prescription Home Delivery Order Form

Mail order form to: The MetroHealth System
Pharmacy Home Delivery Service
9885 Rockside Road
Suite 157
Valley View, OH 44125

Member Information

Last name: _____ First Name: _____ MI: _____ Suffix (Jr., Sr.):_____

DOB: _____ ***Medication Allergies:*** _____

Street address: _____ Apt. /Suite#: _____

City: _____ , OHIO Zip code: _____

Home phone #: _____ Cell phone #: _____

Prescription Information

To order new or refill prescriptions, mail your prescription(s) with this form: # of new: _____ # of refills: _____
To order mail service refills, enter your prescription number(s) here:

1)_____ 2)_____ 3)_____ 4)_____

5) _____6) _____7) _____8) _____

Over the Counter Medications:

_____

_____

Prescriptions sent in one envelope may be shipped together unless you request otherwise

Payment Information: Select one payment method below.

Credit Card: O VISA® O Mastercard® O Discover®

(Mark with an 'X') __ I authorize MetroHealth to charge this card for this order and keep on file for future orders.

Card #: _____Exp. Date (mm/yy): _____

Federal law prohibits the return of dispensed controlled substances.
MetroHealth Mail Order Pharmacy does not allow the return of any dispensed medications.

Should you have any questions about your medication and would like to speak to a pharmacist, please contact us Monday – Friday, 8:30 am – 5:00 pm EST at 216-957-MEDS (6337), option 4.