Enrollment Form

Birdi Customer Service
1-855-247-3479 (TTY 711) or
www.BirdiRx.com

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

First Name	Last Name	MI	Suffix

Member ID	Plan Name

Date of Birth	Gender ☐M ☐F	Number of New Prescriptions	Group Number

Mobile Phone (Include area code)* ☐Set as Preferred Phone	Home Phone (Include area code)* ☐Set as Preferred Phone

Shipping Address Line 1 ☐Use this address for this order only	Billing Address Line 1 ☐Check if same as Shipping Address

Shipping Address Line 2	Billing Address Line 2

City	State	Zip Code	City	State	Zip Code

Email Address (Email used for order status updates)

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, Inc.** 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 your **www.Birdirx.com**.
** By providing your email address you (1) consent to us sending you communications by email about your **Birdi, Inc.** 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

Allergies	☐Aspirin	☐Erythromycin	☐Penicillin	☐Tetracyclines
☐None	☐Cephalosporins	☐NSAIDs	☐Quinolones	☐Other _____
☐Amoxil/Ampicillin	☐Codeine	☐Peanuts	☐Sulfa	_____
Health Conditions	☐Asthma	☐Glaucoma	☐High Cholesterol	☐Thyroid Disease
☐None	☐Cancer	☐Heart Condition	☐Osteoporosis	☐Other _____
☐Arthritis	☐Diabetes	☐High Blood Pressure	☐Pregnancy	_____

Physician Information

Physician Last Name	Physician First Name

Physician Phone (Include area code)	Physician Fax (Include area code)

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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 First Name	Cardholder Last Name

☐ Charge my payment method on file (Returning Customers)
☐ Charge my NEW credit card: ☐ Visa® ☐ Mastercard® ☐ Discover® ☐ American Express®

☐ Ship Expedited Delivery
(Add $25 to my prescription amount)

Credit Card Number	Expiration Date	Security Code

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, Inc.*** receives your prescription.

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

X _____ Cardholder's Signature	Date

☐ Check this box if you **DO NOT** want us to use this payment method for future orders or balance due. You can call ***Birdi, Inc.*** to update this information at any time or you can update your payment preferences by signing in to your account at **www.BirdiRx.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.

Birdi, Inc. wants to provide you with high-quality medicines at the best possible price. ***Birdi, Inc.*** will substitute generic equivalent medicines for brand name medicines, as appropriate by law, unless you or your prescriber indicate otherwise.

By returning this form to ***Birdi, Inc.,*** you certify that the 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. If the patient whose information is provided above is a minor, you represent that you are the patient's legal representative under applicable law and authorized to act on the patient's behalf in completing this Enrollment Form.

X _____ Signature	Date

Mail this completed order form, with your prescription and payment information, to:

Birdi, Inc., P.O. Box 8004, Novi, MI 48376-8004

Ask your doctor to send your prescription electronically to Birdi,Inc., or to fax it to us at: **1-877-395-4836**.

**Please note, we can only accept electronic prescriptions and faxes from your health care provider.

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