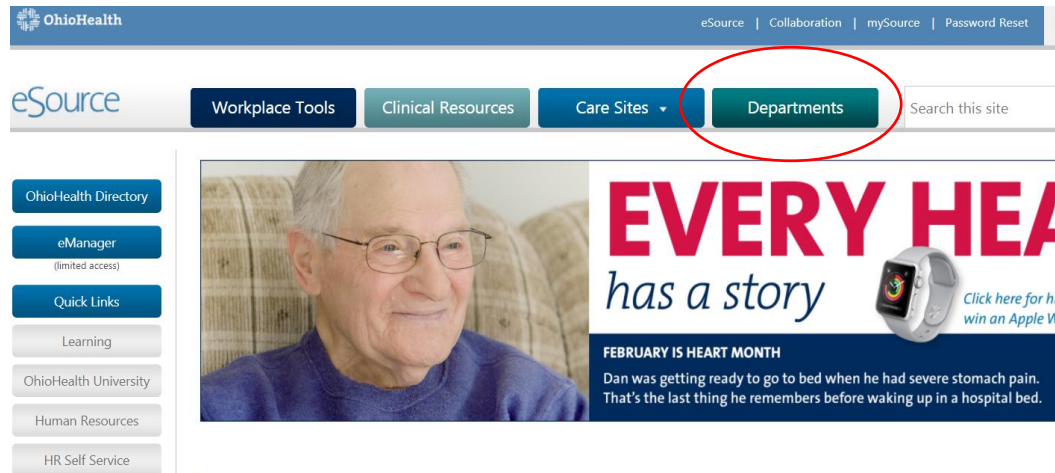
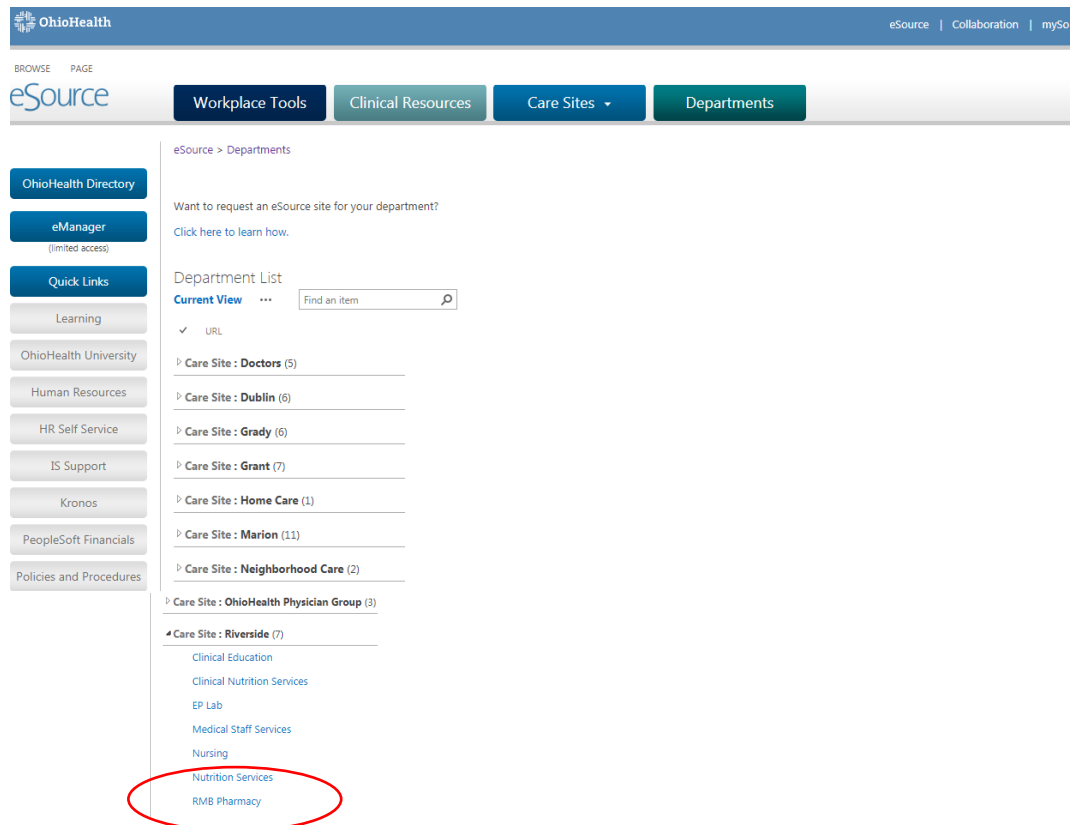


How to fill a new prescription through Riverside Medical Building (RMB) Pharmacy home delivery

1. Visit eSource and search **RMB Pharmacy Mail Order Form**; click form to open, or
2. Select **Departments**.



3. Select **Riverside** and then **RMB Pharmacy**.



4. Select **RMB Pharmacy Mail Order Registration Form**.

How to fill a new prescription through Riverside Medical Building (RMB) Pharmacy home delivery

The screenshot shows the OhioHealth eSource website. The navigation bar includes 'Workplace Tools', 'Clinical Resources', 'Care Sites', and 'Departments'. The main content area is titled 'eSource > Departments > RMB Pharmacy'. It features a 'Welcome!' message with a photo of the RMB Pharmacy. Below this is a 'Documents' section with a table of files:

Name	Modified	Modified By
RMB Pharmacy_Mail Order Registration Dec-2018	December 6, 2017	Paolo-Hohman, Debbie L
RMB TALKING POINTS FOR OHIOHEALTHY	January 18	Paolo-Hohman, Debbie L

Below the documents is a 'MyChart access' section with the text: 'Please begin requesting your prescription refills online through MyChart. The Pharmacy can add your refills to MyChart. You can also request a form to request it. You can also add the app!'. A red circle highlights the link 'Associate RMB Enrollment Resources' which points to the file 'RMB Pharmacy_Mail Order Registration Dec-2018'.

On the right side, there is 'Location Information' for RMB Pharmacy Hours, Phone Number, Fax Number, and Address.

5. Complete and return the form. You can mail, fax or take it in to the RMB Pharmacy.

ASSOCIATE MAIL ORDER DELIVERY PROGRAM

RMB Pharmacy Mail Order Registration Form

(Please fill out all sections of the form. Failure to do so will delay processing)

PLEASE ALLOW 14 DAYS FOR DELIVERY OF YOUR MEDICATION AND PLAN ACCORDINGLY

PATIENT INFORMATION

MEMBER NAME: _____
(Last) (First) (Middle)

MEMBER ID: _____ GENDER: Male Female DATE OF BIRTH: ____/____/____

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME: (____) _____ CELL: (____) _____ WORK: (____) _____

ALLERGIES: None Known Penicillin Codeine Sulfa Others: _____

OhioHealthy INSURANCE INFORMATION

Family members also covered: (Payment information below will apply for all members listed)

Name: _____ DOB: ____/____/____ Person Code: _____

Allergies: _____

Your provider can request a 90-day prescription by phone or ePrescribe to the RMB Pharmacy. You still need to complete the Associate Mail Order Delivery Program form.