

HomeStar Prescription Mail Order Registration Form

If you have any questions concerning HomeStar Mail Order services, please call (610) 628-8900 or Toll Free at 1-855-649-MEDS
Please complete and mail or fax to: HomeStar Mail Order Pharmacy, 77 S. Commerce Way, Suite 230, Bethlehem, PA 18017 | Fax: 610-628-8901

CARDHOLDER INFORMATION

First Name	Middle Name	Last Name
Address		
City	State	Zip
Phone	Alternate Phone	Email

MEMBER AND DEPENDENT INFORMATION (Complete Where Applicable)

Member Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Spouse Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN

BILLING INFORMATION

Billing Address (If different from above) _____

Payment Method (Select One)

Payroll Deduction — Employee Name _____

Credit Card (Circle One) Visa MasterCard Discover

Card Number _____ CCV# _____ Expiration _____

Signature _____

ADDITIONAL INFORMATION

Additional Dependents (Please complete where applicable)

Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN
Dependent Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies		Health Conditions	
Cardholder ID	Group	PCN	BIN