



STEP 1 - COMPLETE YOUR INFORMATION BELOW

Priority Health Medicare OTC 2024 Card or Priority Health Medicare OTC Plus 2024 Card

[illegible]

Member ID (found on plan member ID card)

[illegible]

Date of Birth

First Name

[illegible]

Last Name and Suffix

[illegible]

MI

Street Number

--	--	--	--	--	--

Street Name

[illegible]

Apt/Suite #

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City

[illegible]

State

--	--

Zip Code

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--	--	--	--

Email* (Optional)

[illegible]

@

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Daytime Phone

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*By providing your email address/mobile phone number to us, you consent that we may send communication to you via email/text. Mobile service provider's message and data rates may apply.

Mobile Phone* (Optional)

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STEP 2 - PAYMENT INFORMATION (if applicable)

For orders that exceed your allowance amount, you may use MasterCard, Visa, Discover or American Express to pay the difference to purchase additional items. Sales tax for these items will apply.

Credit or Debit Card # _____

Expiration Date (MM/YY) _____

Cardholder First Name _____ **Cardholder Last Name** _____

Please mail this completed form to the following address:

OTC Servicing Center, PO Box 526266, Miami, FL 33152-9819

If you place your order using an order form, your order total will be applied to the month in which we receive your form. For example, if you mail your order form on June 29, but we receive it on July 1, your order total will be applied to your July allowance, not your June allowance.

STEP 3 - PRODUCT SELECTION

Item #	Product	Quantity	Unit Price	TOTAL
4	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
5	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
6	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
7	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
8	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
9	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
10	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
11	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
12	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
13	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
14	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
15	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
16	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
17	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
18	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Total				\$ <input type="text"/>

A new order form will be provided with your shipment and additional forms can be printed at priorityhealth.com/otc.

Please mail the completed form back in the postage-paid envelope provided.

If you place your order using an order form, your order total will be applied to the month in which we receive your form. For example, if you mail your order form on June 29, but we receive it on July 1, your order total will be applied to your July allowance, not your June allowance.