



Rx Trust Pharmacy
 C/O Canada Health Solutions
 PO BOX 97008 Richmond Main PO., Richmond, British Columbia, V6Y4H4
 Toll Free Phone: 1-800-571-8399 • Toll Free Fax: 1-866-420-8181

How To Place Your Order

NOTE: This order form is for EXISTING Customers ONLY.

STEP 1: Obtain a prescription from your physician for the medications you would like to order. For maximum savings, we recommend you order in bulk, therefore have your doctor write you a **one year prescription in the form of a 3 month supply and 3 refills for EACH medication.**

STEP 2: Complete and sign the **CLIENT INFORMATION & MEDICAL HISTORY** form and the **ORDER INFORMATION & BILLING AUTHORIZATION** form. Fax all completed forms and **ORIGINAL PRESCRIPTIONS** to our toll-free fax at **1-866-420-8181**. You can also mail this information to us at **RxTrustPharmacy.com, PO BOX 97008 Richmond Main PO. Richmond, British Columbia, V6Y4H4**

STEP 3: Upon receipt of your order, a Customer Care Representative will contact you by phone to verify your information and confirm your order. Please allow 2-3 weeks from the day we confirm your order for processing and delivery of your prescriptions. All orders are shipped using Canada Post's Xpresspost – USA shipping service, and are fully insured against loss or damage.

**** For assistance in completing these forms, call us toll-free at 1-800-571-8399 ****

Client Information & Medical History

* Indicates Mandatory Fields

Affiliate ID/CPN Code: _____
(if applicable)

*First Name:		*Last Name:	
*Home Telephone: ()		*Secondary Phone: ()	
*Home Address: Street & Apt. # <small>(only if your address has changed since your last order)</small>			
*City:	*State:	*ZIP:	



Rx Trust Pharmacy
 C/O Canada Health Solutions
 PO BOX 97008 Richmond Main PO., Richmond, British Columbia, V6Y4H4
 Toll Free Phone: 1-800-571-8399 • Toll Free Fax: 1-866-420-8181

Order Information & Billing Authorization

PLEASE ADD ADDITIONAL PAGES IF NEEDED
 * Indicates Mandatory Fields

*Medications Being Ordered (must be accompanied by a valid prescription)			
Drug Name	Strength	Quantity	Refills
1.			
2.			
3.			
4.			
5.			

***Would you like a pharmacist to contact you by telephone to discuss these medications with you? Yes No**

***How would you like to pay for your medications? (Check one only)**

Visa MasterCard American Express Money Order Bank Draft

*** Please make all money orders and bank drafts payable to: Canada Health Solutions ***

*Name on Credit Card:	*Credit Card Number:
*Credit Card Verification Number: <small>(The verification number is a 3-digit number printed on the back of your card. It appears after and to the right of your card number on the signature field.)</small>	*Card Expiry Date: ____/____ (mm/yy)

***Cardholder Address: Street & Apt. # (If different from above)**

*City:	*State:	*ZIP:
---------------	----------------	--------------

***Shipping Address: Street & Apt. # (If different from above)**

*City:	*State:	*ZIP:
---------------	----------------	--------------

***Billing Consent & Authorization**

I, _____, authorize **Canada Health Solutions Inc.**, provider of the RxTrustPharmacy.com service, to apply all applicable charges to my credit card. These charges include the total cost of the drugs ordered, including refills on prescriptions submitted within 90 days, and the \$15.95 shipping and handling fee, which is applied to each package Canada Health Solutions ships me. I understand that a 90-day supply of each medication will be shipped, unless otherwise specified. I also understand that generic substitutions will be made when available, unless otherwise specified, and that all prices and dollar amounts are in United States dollars.

*Cardholder Signature	*Date (mm/dd/yy)
------------------------------	-------------------------