Mail Order Enrollment Instructions for Kroger, PPS

Kroger offers two convenient ways for members to enroll in mail order for prescription drugs

Kroger Mail Order option 1: Calling into Zing Customer Service

- Members can contact Customer Service at 1-866-946-4458 and request assistance with mail order prescriptions
- Our Customer Service Representative will assist you with completing the form and will forward all necessary information to the mail order vendor (Kroger) on your behalf. Please ensure you have the following information available during the call:
    - Name and strength of medication(s)
    - Pharmacy name and number
    - Prescription number
    - Primary care physician name and number
    - Information as to how you would like to be contacted (email, text, phone)
- Customer Service will follow up with you to track delivery and receipt of medications

Kroger Mail Order option 2: Mailing the form to the vendor

- Members can download the Kroger mail order form by visiting the website at www.myzinghealth.com and mail the completed form directly to Kroger (PPS)
- Members may also contact Customer Services at 1-866-946-4458 and request a form be mailed

Need Help?

Please call or email Zing Health Customer Service
Phone: 1-866-946-4458 (TTY: 711)
Email: customerservice@myzinghealth.com

Tear here, insert order form in envelope and seal.

PPS
Postal Prescription Services®

Date I mailed my order ____________ Co-pay Amount Enclosed $____________

Tear here, and keep this stub for your records.

Questions?
call: 1-800-552-6694
in Portland, Oregon:
(503) 797-2100

Health Care Plan Information

Health Care Plan

Employer Name (if applicable)

Insured's I.D. Number

Insured's Name

If possible, please enclose a copy of your insurance card when placing your initial order or when changing insurance.

Patient Information

Primary

Last Name First Name M.I.

/ / Date of Birth ☐ ✔ Male ☐ ✔ Female

Doctor/Prescriber name and Phone No.

✔ **Drug Allergies / Health Condition**

☐ NONE ☐ CODEINE ☐ PENICILLIN ☐ SULFA
☐ ASPIRIN ☐ OTHER ______

☐ ASTHMA ☐ DIABETES ☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE ☐ HYPERLIPIDEMIA
☐ OTHER ______

Spouse

Last Name First Name M.I.

/ / Date of Birth ☐ ✔ Male ☐ ✔ Female

Doctor/Prescriber name and Phone No.

☐ NONE ☐ CODEINE ☐ PENICILLIN ☐ SULFA
☐ ASPIRIN ☐ OTHER ______

☐ ASTHMA ☐ DIABETES ☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE ☐ HYPERLIPIDEMIA
☐ OTHER ______

Dependent

Last Name First Name M.I.

/ / Date of Birth ☐ ✔ Male ☐ ✔ Female

Doctor/Prescriber name and Phone No.

☐ NONE ☐ CODEINE ☐ PENICILLIN ☐ SULFA
☐ ASPIRIN ☐ OTHER ______

☐ ASTHMA ☐ DIABETES ☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE ☐ HYPERLIPIDEMIA
☐ OTHER ______

Ship To This Address

Last Name First Name Middle Initial

Street Address

City State Zip Code

Home Phone ( )

Day Phone ( )

Thank You.
We appreciate your business!

- Order *prescription refills* or transfers here by enclosing refill slips or filling out this section

✔ For *new prescriptions*, enclose the prescription in the envelope provided and check here.

Qty.	Prescription No.	Name of Medication	Strength	Pharmacy Name	Pharmacy Phone	Doctor's Name & Phone	Price or Co-Pay
						Total: $	

Non-Safety Cap Request Information:

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 your prescription with an "easy-open" lid please sign below. **I do not want safety caps:**

X ______________________________
Patient's Signature Here Date

Method of Payment:

☐ Check ☐ Money Order ☐ Visa/MasterCard ☐ Discover ☐ Am. Express

Credit Card Number Exp. Date

X ______________________________
Cardholder's Signature

Make check or money order payable to:

PPS
Postal Prescription Services®