Harness Health Pharmacy

Harness Health Pharmacy is the new name for Bon Secours Mercy Health's on-site retail pharmacies and centralized home delivery and specialty drugs pharmacy.

Associate Enrollment Form

Harness Health Pharmacy Home Delivery offers a convenient way to get the medications you need – when and where you need them!

Step 1: Send us your information

To begin home delivery, complete this form in its entirety and return it by:

Mail –
Harness Health Pharmacy
7160 Industrial Row Drive, Suite 330
Mason, OH 45040

Fax – 513-557-7675

Or call – 866-775-5767

If you access this form online, you can complete the form by keying in your information. Print to add the Cardholder Signature and Associate Signature, then return as directed.

Step 2: Ask your provider for a new prescription

Request new prescription(s) be sent to Harness Health Pharmacy (formerly Mercy Health Pharmacy) by contacting your provider, either by phone or via any secure system that allows you to access portions of your medical records. Ask for a 90-day supply of a medication – with refills up to one year, if appropriate – for the lowest cost to you.

The provider can submit a prescription by:

E-Prescription – Harness Health – Home Delivery

Fax – 513-557-7675

Phone – 866-775-5767

Call us to start the process to transfer your prescriptions directly from your local pharmacy.

Step 3: Receive confirmation

After receipt, we'll call you to be sure we have everything we need to provide your pharmacy services.

Have Questions? Call Us!

To learn more about home delivery or for help from our Clinical Pharmacy team, call us at **866-775-5767**. We look forward to helping you! Our hours of operation are weekdays 8 a.m. -- 4:30 p.m. ET.

Associate Information

M / F

Full Name: ____ M / F

First *Middle* *Last* *Gender*

Address: ____

Street Address *Apartment/Unit #* *City* *State* *ZIP Code*

Birth Date:________________Home Phone:______________________Cell Phone: __________________

E-Mail Address:____________________

Harness Health Pharmacy may use my email address to:

- notify me when a package has been shipped. ☐ Yes ☐ No
- sign me up for prescription copay savings cards on my behalf when available. ☐ Yes ☐ No

Medication and Food Allergies:____

Patient	Prescriber Name	Prescriber Phone #	Drug Name and Dosage Strength	I will include the prescription with this form	Please contact my doctor for this prescription
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O
				O	O

Dependent Information

Name:________________________________DOB:_______________Med. Allergies:_________________________

Preferred Phone: ______________________Email:______________________________________

Name:________________________________DOB:_______________Med. Allergies:_________________________

Preferred Phone: ______________________Email:______________________________________

Name:________________________________DOB:_______________Med. Allergies:_________________________

Preferred Phone: ______________________ Email:______________________________________

Prescription Insurance Information

Name of insurance	Cardholder or Member Rx ID Number	BIN #

Rx Group Number	Rx PCN	Customer Service Phone Number (from back of card)
PHE _ _		

Payment Information – *Please provide a credit card in addition to any Benefit Card you have.*

Cardholder Name	Cardholder Signature

Card Type	Account Number	Expiration Date
Benefit Card (HRA/ Health Care FSA Card)		
Credit Card (Visa, MC, Discover, Amex)		

Please Read and Sign

By signing the information below, I acknowledge:

- Harness Health Pharmacy will substitute generic formulations unless I or my prescriber indicates otherwise in advance.
- I am providing Harness Health Pharmacy with payment information that will be used to process any copayment or coinsurance. I authorize this information to be retained for future payments. Harness Health Pharmacy will use it to process copayment or coinsurance when I request refills.
- I understand that I may contact Harness Health Pharmacy to speak with a pharmacist at **866-775-5767**.

Associate Signature ____ Date _________________