Request for
Restriction of Protected Health
Information for Services & Treatment

I hearby request restriction on the disclosure of my protected information to the health plan for payment or healthcare operations for the fulfillment of the attached prescription or refill. I understand and agree that I must pay the full cost for the prescription(s) and this request is only valid for this prescription(s) and does not apply to any subsequent refills. Payments may be made by personal check, money order, debit or credit card. Health Savings Accounts or Flexible Spending Accounts can not be used for this request.

Please print the following information:

Member name: _____ Date of birth: _____

Daytime phone: _____ Alternative Phone: _____

Address: _____

Member signature: _____ Date: _____

Legal representative signature*: _____ Date: _____
(*only if member is unable to sign)

Name of prescription to be restricted: _____

Name of prescribing provider: _____

Please print the following information on the back of each prescription:

- Member name
- Date of birth
- Shipping address

Please note: If you are a legal representative for the member, you must attach copies of your authorization as required by state law to represent the member – for example, healthcare power of attorney, healthcare surrogate, living will, or guardianship papers.

To prevent a delay in fulfilling your request, please verify all fields on this form are complete and accurate and that you have attached prescription and payment.

Please send this form to:
Humana Pharmacy
P.O. Box 745099
Cincinnati, OH 45274-5099

Prescriptions may be filled or processed by any of the Humana Pharmacy locations. In order to comply with certain federal and state laws, and to ensure the integrity of medications dispensed, all Humana Pharmacy sales are final. Payment is due at the time of shipment.

Discrimination is Against the Law
Humana Pharmacy, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-379-0092 (TTY: 711).

Español (Spanish): ATENCIÓN: habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-379-0092 (TTY: 711).

繁體中文**(Chinese)**: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-379-0092 (TTY：711)。