



We Deliver! order form

Please fill out this form and FAX it to (317) 637-4328. Or, send it via U.S. mail to:

Planned Parenthood of Indiana – We Deliver!
3200 Sycamore Court, Suite 2C
Columbus, IN 47203-1552

Personal contact information *(required)*

Your full name: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Telephone number: _____

May we call you at this phone number & say we're calling from Planned Parenthood of Indiana (only if we need to verify information)? Yes No

Email address: _____

Billing information *(required)*

My billing information is the same as I've listed above: Yes No

Billing name: _____

Billing address: _____

City: _____ State: _____ ZIP: _____

Patient eligibility *(required)*

Date of birth: ____/____/____ Planned Parenthood patient # (if known): _____

Your Planned Parenthood health center: _____

Type of contraceptive supply: Birth control pills – Name of pill (if known): _____

Orth Evra® patch

“**Order As You Go**” plan (just this one time) – Number of months worth: _____

I'd like to pay via Credit Card I have Indiana Medicaid

“**Automatic Ordering**” plan (every 3 months) – Date to receive your first order: ____/____/____

I'd like to pay via Credit Card I have Indiana Medicaid

By selecting the "Automatic Ordering" plan, I understand that:

1. By joining the automatic ordering plan, every three (3) months Planned Parenthood of Indiana will send me three (3) packs of the contraceptives that I am prescribed. They will be mailed to the address given two (2) weeks before I am scheduled to need my contraceptive supplies.
2. Planned Parenthood of Indiana wants to help me with my health care needs. If I have any questions or problems, or if my supplies do not arrive on time, I will call or visit the health center. I am ultimately responsible for using my contraceptives correctly.
3. I must have all previous balances paid in full before starting this plan. I also must have the current three-month supply paid off before the next three-month supply will be sent.
4. If I want to discontinue my plan, I will notify Planned Parenthood of Indiana 14 days before the next packages are sent to me. I must pay for any supplies mailed prior to discontinuing the plan.
5. I must notify Planned Parenthood of any address change. I must pay for supplies that are returned due to a wrong address.

Signature (required): _____

Billing information (required)

I have Indiana Medicaid. Enclosed is my check or money order for \$ _____

If you don't bill your supplies to a credit card, you must include payment with your order.

Charge to my:    

Your name as it appears on your credit card: _____

Credit card #: _____ Exp. date: ____/____/____

CCV/CVV2 code: _____ Signature (required): _____

Send my supplies via...

- U.S. Standard Mail, up to 14 days: \$4.00
- U.S. Priority Mail, 2-3 days: \$7.95
- U.S. Express Mail, overnight \$20.50 *Additional fees will apply for shipments to Alaska & Hawaii.*

Ask us any questions you have about We Deliver: _____

**By submitting this form, I understand that these are prescription medications,
and therefore cannot be returned and/or refunded.**

All payments are final.