Mail Request: Birth Control Pills and Condoms

Cleveland
7997 Euclid Ave.
Cleveland, OH 44103
216-851-1880
Fax: 216-707-9370

Lorain
200 W 9th St.
Lorain, OH 44052
440-242-2087
Fax: 440-242-2089

Old Brooklyn
PO Box 609009
Old Brooklyn, OH 44109
216-661-0400
Fax: 216-661-2238

Rocky River
20800 Center Ridge Rd.
Suite 101
Rocky River, OH 44116
440-331-8744
Fax: 440-331-4245

If you are having problems with your pills, please do not request a refill.
Call the office and schedule an appointment.

Please complete this form and return with payment to the appropriate office,
Or fax your order with your credit card (AMEX/Visa/Master Card/Discover)/debit card number.

Name: ______________________________

Date of Birth: ______________ **Phone Number:** ______________________

If we call, may we identify ourselves as:

- ☐ **Planned Parenthood** ☐ **Drs. Office** ☐ **Code Name:** ____________

Address where you would like your pills to be mailed:

If you do not live at this address, please provide the name of the person that will be receiving your pills! Otherwise you may not receive your order!

C/o: ______________________________

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All orders must be prepaid (except Medicaid) and Client must sign below. Please allow 14 days for delivery.

I wish to receive_____pack(s) of birth control pill(s) and/or ____ dozen condoms.
To calculate how much you need to send:

Cost per pack ________ **multiply** by # ______of pack(s) = $__________
Cost per dozen of condoms ________ **multiply** by # ______ of dozen = $__________

TOTAL DUE = $__________

Method of Payment:

☐ Medicaid – Please circle plan:

Traditional Buckeye CareSource Molina
Wellcare United HealthCare Community Plan

☐ Check #___________ ☐ Money Order______________________

☐ Credit Card

Type (please circle)

Card number: ____________________________SEC code* ________ Exp. Date_______

** For Visa, MC and Discover this is the last 3 digits on the signature line on the back of the card. For American Express this is the 4-digit code on the front of the card.*

Complete billing address (where credit card statement is mailed): ______________________

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Name as it appears on credit card: ______________________________

Cardholder Signature: ______________________________Date: ______________

Office Use Only

You now have ______ packs of ______________________ left on your order with Planned Parenthood. Your order expires______, please schedule an appointment before this date.

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Place Client Label Here

Thank you for your order!