

# Wegmans Mail Order Pharmacy Service Sign-Up Form

- Please complete this form and mail it to: Wegmans Pharmacy Free Home Shipping  
P.O. Box 64472  
Rochester, NY 14624
- If you need assistance, please call our Mail Order Customer Service line at 1-888-205-8573.
- Once your prescription is delivered, go to [www.Wegmans.com/pharmacy](http://www.Wegmans.com/pharmacy) to set up your Wegmans pharmacy online profile.
- If you need to add more Additional Family Members or Prescriptions, please use a separate piece of paper. Please include all of the information that is requested on the form.

## Cardholder Information:

<b>First Name</b>		<b>MI</b>		<b>Last Name</b>		<b>Suffix</b>		<b>Date of Birth (MM/DD/YYYY)</b>	
<b>Permanent Address</b>									
<b>City</b>								<b>State</b>	<b>Zip Code</b>
<b>Email Address (for shipping notification)</b>							<b>Preferred Phone Number</b>		
							Check one: <input type="radio"/> Home <input type="radio"/> Cell		
<b>Cardholder ID</b>			<b>Group ID</b>						
<b>Gender:</b>			<b>Drug Allergies:</b>						
<input type="radio"/> Male <input type="radio"/> Female			<input type="radio"/> None <input type="radio"/> Codeine <input type="radio"/> Penicillin <input type="radio"/> Aspirin <input type="radio"/> Sulfa <input type="radio"/> Other: _____						

## Additional Family Members:

<b>First Name</b>		<b>MI</b>		<b>Last Name</b>		<b>Suffix</b>		<b>Date of Birth (MM/DD/YYYY)</b>	
Same Address as Cardholder <input type="radio"/>									
<b>Alternate Address</b>									
<b>City</b>								<b>State</b>	<b>Zip Code</b>
<b>Relationship to Cardholder:</b>			<b>Gender:</b>			<b>Drug Allergies:</b>			
<input type="radio"/> Spouse <input type="radio"/> Child			<input type="radio"/> Male <input type="radio"/> Female			<input type="radio"/> None <input type="radio"/> Codeine <input type="radio"/> Penicillin <input type="radio"/> Aspirin <input type="radio"/> Sulfa <input type="radio"/> Other: _____			

<b>First Name</b>		<b>MI</b>		<b>Last Name</b>		<b>Suffix</b>		<b>Date of Birth (MM/DD/YYYY)</b>	
Same Address as Cardholder <input type="radio"/>									
<b>Alternate Address</b>									
<b>City</b>								<b>State</b>	<b>Zip Code</b>
<b>Relationship to Cardholder:</b>			<b>Gender:</b>			<b>Drug Allergies:</b>			
<input type="radio"/> Spouse <input type="radio"/> Child			<input type="radio"/> Male <input type="radio"/> Female			<input type="radio"/> None <input type="radio"/> Codeine <input type="radio"/> Penicillin <input type="radio"/> Aspirin <input type="radio"/> Sulfa <input type="radio"/> Other: _____			

MD Name	MD Phone #	MD Address	
	( ) -		
Drug Name/Strength	Patient name	I will include prescription with this form	Please contact my doctor for this prescription
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>

**Shipping Information:**

Shipping Address (only if different than permanent address)

																										State	Zip Code
City																											

**Payment Information**

**Credit Card** (we accept American Express®, Discover®, MasterCard® and Visa®)

**Card Type:**  American Express®  Discover®  MasterCard®  Visa®

Credit Card Number	Expiration (MM/YY)

Card Holder's First Name	MI	Card Holder's Last Name	Suffix	Date of Birth (MM/DD/YY)

**Billing Address**

																										State	Zip Code
City																											

By signing below, I authorize Wegmans to charge the credit card identified above for this order and all future orders associated patient(s) listed above, and that at my verbal request; Wegmans may update the cardholder name, billing address and/or credit card expiration date on file.

Cardholder Signature \_\_\_\_\_ Date: \_\_\_\_\_