

Mail this form to: Wegmans Pharmacy Home Delivery P.O. Box 64472 Rochester, NY 14624

- Please complete this form and mail it to us at the address below with your original, prescribersigned prescription(s).
- If you need assistance, please call our Mail Order Customer Service line at1-800-934-4797.
- Once your prescription is delivered, go to <u>www.Wegmans.com/pharmacy</u> to set up your Wegmans pharmacy online profile.

## Patient Information:

First Name MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)
Permanent Address			
City			State Zip Code
Email Address (for shipping notification			Preferred Phone Number
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	alerts regarding the status of your order?	neck one:	⊃ Yes⊖ No
would you like Automatic Kerni for you			
Insurance Information:	○ Codeine ○ Penicillin ○ Aspirin ○ Sul		ner:
Rx BIN Rx PCN	Cardholder ID Rx (	GRP	
Relationship to Cardholder:			
○ Cardholder ○ Spouse ○ Child			
Shipping Information:			
Delivery Method: OStandard (5-10 k	usiness days): No Charge O1-2 business	<b>days</b> : \$12	.95
Shipping Address (only if different than	permanent address)		
City			State Zip Code

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## Prescriptions:

Patient	MD Name	MD Phone #	Drug Name/Strength	I will include prescription with this form	Please contact my doctor for this prescription.
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## **Payment Information**

Use credit card already on file, with OR	h last 4 digits of:							
Add a New Credit Card (we accept	American Expres	ss <sup>®</sup> , Discover <sup>®</sup> , Maste	erCard <sup>®</sup> and Vi	sa®)				
Card Type: O American Express®	○ Discover <sup>®</sup>	○ MasterCard <sup>®</sup>	○ Visa®					
Credit Card Number	Expiration (M	M/YY)						
Card Holder's First Name M	II Card Holder's	s Last Name	Suffix	Date o	f Birth (	(MM/	DD/YY)	)
Card Holder's First Name M	II Card Holder's	s Last Name	Suffix	Date o	f Birth (	(мм/	DD/YY) /	)
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IF using the same credit card information for all patients associated with this form, please list all patients below:

## **Additional Patients:**

First Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)
First Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)
First Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)

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

Cardholder Signature\_\_\_\_\_Date:\_\_\_\_\_\_Date:\_\_\_\_D

IF you will be using a <u>different</u> credit card for other patients listed on this form, please include payment information for these patients below:

irst Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)
irst Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)
irst Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)
⊃Use credit card already on file,	with	last 4 digits of:		
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<b>Card Type</b> : O American Expre	SS®	○ Discover <sup>®</sup> ○ MasterCard <sup>®</sup> ○	Visa®	
Credit Card Number		Expiration (MM/YY)		
Card Holder's First Name	мі	Card Holder's Last Name	Suffix D	ate of Birth (MM/DD/YY)
Billing Address				
City			St	ate Zip Code
By signing below, I authorize	Wegm	ans to charge the credit card identified ab	ove for this c	order and all future
orders associated with this pa	tient	and additional patient(s) listed above, and	that at my ve	erbal request;
Wegmans may update my bill	ing ac	dress and/or credit card expiration date o	n file.	
Cardholder Signature		D	ate:	
For Internal Lise Only				

For Internal Use Only	
Signature:	Date Received: