Home Delivery Service Sign-Up Form

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, prescriber-signed 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 www.Wegmans.com/pharmacy 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**

( )

Would you like to receive Text message alerts regarding the status of your order? **Check one:** ○ **Yes** ○ **No**

Would you like Automatic Refill for your prescriptions? **Check one:** ○ **Yes** ○ **No**

Gender:
○ Male ○ Female

Drug Allergies:
○ None ○ Codeine ○ Penicillin ○ Aspirin ○ Sulfa ○ Other:

Insurance Information:

Rx BIN **Rx PCN** **Cardholder ID** **Rx GRP**

Relationship to Cardholder:
○ **Cardholder** ○ **Spouse** ○ **Child**

Shipping Information:

Delivery Method: ○ **Standard (5-10 business days)**: No Charge ○ **1-2 business days**: $12.95

Shipping Address (only if different than permanent address)

City **State** **Zip Code**

Additional Family Member (1):

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**

( )

Would you like to receive Text message alerts regarding the status of your order? **Check one:** ○ **Yes** ○ **No**

Would you like Automatic Refill for your prescriptions? **Check one:** ○ **Yes** ○ **No**

Gender:
○ Male ○ Female

Drug Allergies:
○ None ○ Codeine ○ Penicillin ○ Aspirin ○ Sulfa ○ Other:

Insurance Information:

○ **Same as above**

Rx BIN **Rx PCN** **Cardholder ID** **Rx GRP**

Relationship to Cardholder:
○ **Cardholder** ○ **Spouse** ○ **Child**

Shipping Information:

○ **Same as above**

Delivery Method: ○ **Standard (5-10 business days)**: No Charge ○ **1-2 business days**: $12.95

Shipping Address (only if different than permanent address)

City **State** **Zip Code**

Additional Family Member (2):

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**

( )

Would you like to receive Text message alerts regarding the status of your order? **Check one:** ○ **Yes** ○ **No**

Would you like Automatic Refill for your prescriptions? **Check one:** ○ **Yes** ○ **No**

Gender:
○ Male ○ Female

Drug Allergies:
○ None ○ Codeine ○ Penicillin ○ Aspirin ○ Sulfa ○ Other:

Insurance Information:

○ **Same as above**

Rx BIN **Rx PCN** **Cardholder ID** **Rx GRP**

Relationship to Cardholder:
○ **Cardholder** ○ **Spouse** ○ **Child**

Shipping Information:

○ **Same as above**

Delivery Method: ○ **Standard (5-10 business days)**: No Charge ○ **1-2 business days**: $12.95

Shipping Address (only if different than permanent address)

City **State** **Zip Code**

Additional Family Member (3):

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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Would you like to receive Text message alerts regarding the status of your order? **Check one:** ○ **Yes** ○ **No**

Would you like Automatic Refill for your prescriptions? **Check one:** ○ **Yes** ○ **No**

Gender:
○ Male ○ Female

Drug Allergies:
○ None ○ Codeine ○ Penicillin ○ Aspirin ○ Sulfa ○ Other:

Insurance Information:

○ **Same as above**

Rx BIN **Rx PCN** **Cardholder ID** **Rx GRP**

Relationship to Cardholder:
○ **Cardholder** ○ **Spouse** ○ **Child**

Shipping Information:

○ **Same as above**

Delivery Method: ○ **Standard (5-10 business days)**: No Charge ○ **1-2 business days**: $12.95

Shipping Address (only if different than permanent address)

City **State** **Zip Code**

Prescriptions:

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

Payment Information

⬭ **Use credit card already on file**, with last 4 digits of: ☐☐☐☐

OR

⬭ **Add a New 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

City **State** **Zip Code**

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:_____

IF you will be using a **different** credit card for other patients listed on this form, **please include payment information for these 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)

○ **Use credit card already on file**, with last 4 digits of:

OR

○ **Add a New 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

City **State** **Zip Code**

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:_____

For Internal Use Only	
Signature:	Date Received: