Free Home Shipping New Rx Order Form

- **Please complete this form and mail it to us at the address below with your original, prescriber-signed prescription(s).**
- **If you wish to fill prescriptions for multiple patients, please fill out multiple forms.**
- **You will be notified if extra processing time is required for prescriptions that need prescriber clarification.**
- **For refills or any additional services, please visit: www.wegmans.com/pharmacy or call 1-800-934-4797**

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

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**

( )

Check one: ○ **Home** ○ **Cell**

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 ○ **Express (1-2 business days)**: $18.95

Shipping Address (only if different than permanent address)

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

Prescriptions:

MD	MD Phone #	MD Address

	Select One:		Select One:	
Drug Name/Strength	I will include this prescription with this form	Please contact my doctor for this prescription	Fill Now	Place on hold for later fill
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○

MD	MD Phone #	MD Address

	Select One:		Select One:	
Drug Name/Strength	I will include this prescription with this form	Please contact my doctor for this prescription	Fill Now	Place on hold for later fill
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○

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)**

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

Billing Address

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

Please choose **one** of the following options:

○ Place the credit card information above on file for recurrent use for **only the patient associated with this order.**

○ Place the credit card information above on file for the recurrent use for the **patient associated with this order and future orders for additional patients.** (List additional patients below)

Additional Patients:

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:________________________

For Internal Use Only	
Specialist Signature:	Date Received: