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 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:

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**

Cardholder ID **Group ID**

Gender:
○ Male ○ Female

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

Additional Family Members:

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

/ /

Same Address as Cardholder ○

Alternate Address

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

Relationship to Cardholder:
○ Spouse ○ Child

Gender:
○ Male ○ Female

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

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

/ /

Same Address as Cardholder ○

Alternate Address

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

Relationship to Cardholder:
○ Spouse ○ Child

Gender:
○ Male ○ Female

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

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

/ /

Same Address as Cardholder ○

Alternate Address

City | State | Zip Code

Relationship to Cardholder: ○ Spouse ○ Child

Gender: ○ Male ○ Female

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

Prescriptions:

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**
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○

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
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○

Shipping Information:

Shipping Address (only if different than permanent address)

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

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)**

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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**

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:_______________________