

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)	
<input type="text"/>					
Permanent Address					
<input type="text"/>					
City				State	Zip Code
<input type="text"/>					
Email Address (for shipping notification)				Preferred Phone Number	
<input type="text"/>				<input type="text"/> (<input type="text"/>) <input type="text"/> <input type="text"/>	
<input type="text"/>					
Cardholder ID		Group ID			
<input type="text"/>					
Gender:		Drug Allergies:			
<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:

First Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)	
<input type="text"/>					
Same Address as Cardholder <input type="radio"/>					
Alternate Address					
<input type="text"/>					
City				State	Zip Code
<input type="text"/>					
Relationship to Cardholder:		Gender:		Drug Allergies:	
<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: _____	

First Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)	
<input type="text"/>					
Same Address as Cardholder <input type="radio"/>					
Alternate Address					
<input type="text"/>					
City				State	Zip Code
<input type="text"/>					
Relationship to Cardholder:		Gender:		Drug Allergies:	
<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"/>

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)

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: _____