Verified and Checked by_____ ***PLAN YEAR 2022 – 2023*** **Registration Update YES / NEW**

RUBENSTEIN MEMORIAL HALL HEALTH CENTER PHARMACY
Room 105 Hall Health, Seattle, WA 98195
Telephone (206) 685-1021 or Email – pharmacy@u.washington.edu

MAIL ORDER PATIENT REGISTRATION FORM
For the GRADUATE APPOINTEE INSURANCE PLAN and ELIGIBLE FAMILY MEMBERS

NAME: _____**DATE**_____

Patient / Student # _____ **Patient Birth Date**_____

ADDRESS: _____

_____

PHONE # _____**EMAIL ADDRESS**_____

INSURANCE ID # _____ **Rx GROUP #** _____

PAYMENT METHOD ◯ **VISA** ◯ **MC** **Please remember to update your credit card before expiration**

CREDIT CARD # _____ **EXP DATE:** _____ **V-CODE**_____

***Payment Agreement Signature**_____ **Date**_____

***Receipt of mailed prescriptions will be the responsibility of the patient. Any medications lost or stolen **will not** be replaced. ***
I would like to have postal insurance on any package whose retail replacement cost exceeds $400. Packages with replacement costs under $400 will not be insured unless specified by the patient. (Neither the UW GAIP insurance or the pharmacy will not cover the cost of lost medication and does not pay to replace the medication until the appropriate time for the next refill has passed) I understand that I will be charged the appropriate postal insurance fee added to the mailing charges. **YES ◯ / ◯ NO**

I _____ authorize the Hall Health Center Pharmacy to process and charge my insurance policy and credit card for my prescription(s) including all monies owed by me for the prescriptions and the mailing fees as determined.

***Signature**_____**Date**_____

I have read and agree to the statements made in the Mailing Agreement and agree to abide by them.

Print Name_____**Signature**_____**Date**_____

For **Dependent Patients**, please complete the following

Insurance Cardholder_____ Cardholder's Student # _____

Insurance Cardholder's Date of Birth_____