Verified and Checked by__________ *PLAN YEAR 2015 – 2016* **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: ____

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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**_______

1. Do you have insurance other than **UW health insurance** (i.e. as a dependent on a spouse's or parents' plan)? **YES / NO**
Note: the GAIP insurance is a secondary plan. If you checked "Yes", you must bill your primary insurance plan first then self submit the co-pay to the UW insurance plan.

2. Any changes to the insurance plan must be updated with the pharmacy **immediately** so that the correct insurance will be billed.

***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___________________________