

Verified and Checked by \_\_\_\_\_

**PLAN YEAR 2019 – 2020**

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](mailto:pharmacy@u.washington.edu)



**MAIL ORDER PATIENT REGISTRATION FORM**

For the **GRADUATE APPOINTEE** INSURANCE PROGRAM and **ELIGIBLE FAMILY MEMBERS**

NAME: \_\_\_\_\_ DATE \_\_\_\_\_

Patient / Student # \_\_\_\_\_ Patient Birth Date \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE # \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

INSURANCE ID # \_\_\_\_\_ Rx GROUP # \_\_\_\_\_

PAYMENT METHOD



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 \_\_\_\_\_