Traditional Mail Order service PATIENT PROFILE FORM

Thank you for choosing to use the Traditional Mail Order service offered by Costco Mail Order Pharmacy. Please complete, sign, and return this form only if this is your first time using our Mail Order Pharmacy. If you need additional copies of this form, please feel free to make a photocopy or contact Costco Mail Order Pharmacy at 1-800-607-6861. Our goal is to have your prescription order returned to you within 14 days. To avoid a delay in your order, please ensure you complete the entire form, front and back, provide payment information, and include a prescription(s) from your physician for the maximum days supply allowed (90-day supply for most maintenance medications)..

SHIPPING INFORMATION Please tell us where we should ship your order(s).

LAST NAME | FIRST NAME | MI

SHIPPING ADDRESS (INCLUDE APT. NO. IF APPLICABLE) | CITY | STATE | ZIP

PHONE NUMBER (INCLUDING AREA CODE) | COSTCO MEMBERSHIP NO. (OPTIONAL)

YES ☐ NO ☐

DO YOU WISH TO RECEIVE EMAIL REFILL AND RENEWAL REMINDERS?

INSURANCE INFORMATION

MEMBER ID NO. | RX BIN NO. (SEE YOUR PRESCRIPTION ID CARD) | GROUP NO.

POLICYHOLDER NAME | POLICY HOLDER DATE OF BIRTH (MM/DD/YYYY)

HEALTH PROFILE Please fill in the appropriate box(es) below for each member of the family that is covered. If additional space is needed, please attach a separate sheet with additional information.

	CARDHOLDER	SPOUSE	DEPENDENT	DEPENDENT	DEPENDENT
LAST NAME					
FIRST NAME					
MIDDLE INITIAL					
DATE OF BIRTH (MM/DD/YYYY)					
EMAIL ADDRESS (OPTIONAL)*					
SEX	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐

Drug Allergies Please check the appropriate box(es) where a drug allergy is known.

	CARDHOLDER	SPOUSE	DEPENDENT	DEPENDENT	DEPENDENT
No known allergies	☐	☐	☐	☐	☐
Erythromycin	☐	☐	☐	☐	☐
Penicillin	☐	☐	☐	☐	☐
Codeine	☐	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐	☐
Sulfa	☐	☐	☐	☐	☐
Other					

Medical Conditions Please check the appropriate box(es) for known medical conditions.

No known diseases	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Other					

FORM CONTINUED ON REVERSE

*Each family member will need to provide a unique email address.

Your prescription will be filled with a generic equivalent if one is available.
Check this box if you do not want a generic equivalent. ☐NO GENERICS EASY-OPEN CAPS: ☐YES ☐NO

Note: By checking this box I understand that, depending on my plan benefits, I may be responsible for the brand co-payment, which may be higher, and any plan penalties that may apply.

PAYMENT OPTIONS – Please select a payment choice below and provide the requested information:

Billing information: ☐Check here if same as shipping address

BILLING ADDRESS (INCLUDE APT. NO. IF APPLICABLE) CITY STATE ZIP

☐**Credit Card –** You authorize Costco Mail Order Pharmacy to charge your credit card to pay for each pharmacy order. Charge dates and amounts will vary with each order.

☐American Express® ☐Costco Credit Card ☐Visa ☐MasterCard ☐Discover

NAME AS IT APPEARS ON CARD CARD NO. EXP. DATE (MM/YY)

SHIPPING OPTIONS – Please select a shipping method below. Allow 1 – 4 days to process order.

☐ **Standard shipping –** (Average process and delivery time: 6 – 14 days) **FREE (USPS)**
☐ **3-Day shipping –** (Average process and delivery time: 3 – 6 days) **$10.95 (UPS)***
☐ **2-Day shipping –** (Average process and delivery time: 2 – 5 days) **$13.95 (UPS)***

*UPS will not deliver on weekends and cannot ship to P.O. Boxes.

Calculated total process and delivery time starts once the order is first received at the pharmacy. Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.

Before you mail this form please check for the following:
❑ You have included your maintenance medication prescription(s) for a 90-day supply.
❑ You have provided valid payment and shipping information.
❑ Your name, address, phone number and date of birth are included on all documents including your prescription(s).
❑ You have attached a separate sheet for additional dependent information or additional instructions.

ADDITIONAL INFORMATION:

Please send only prescriptions to be ordered immediately. We will not hold your prescriptions. Your order should arrive 14 days after we receive this form and your prescription(s) at our facility.
Mail required forms and prescription(s) to: Costco Mail Order Pharmacy, 802 134th St. SW, Suite 140, Everett, WA 98204-9935.
If you have any questions or need assistance, call Costco Mail Order Pharmacy at 1-800-607-6861.

AUTHORIZATION

By signing below you agree that the information on this form is correct, and authorize release of all information regarding your medical and prescription drug history and treatment to Costco Mail Order Pharmacy. I understand that my prescription order(s) will be fulfilled and shipped upon receipt of my complete order form, the original prescription(s) and applicable payment.

CARDHOLDER SIGNATURE DATE