



Traditional Mail Order Service Patient Profile Form and Payment Authorization 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 or EnvisionRxOptions at 1-800-361-4542. 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 of 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 E-MAIL REFILL AND RENEWAL REMINDERS? E-MAIL ADDRESS (optional)

By checking this box I authorize Costco Pharmacy to include some or all of the following information: drug names, dates, quantity, dosage and available refills.

PHYSICAL ADDRESS

 Only complete this section if your shipping address is a P.O. Box.

PHYSICAL ADDRESS (INCLUDE APT. NO. IF APPLICABLE)	CITY	STATE	ZIP
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INSURANCE INFORMATION

 EnvisionRxOptions BIN – 009893 PCN – roirx

MEMBER ID NO.	GROUP NO.
POLICY HOLDER 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)					
SEX	M <input type="checkbox"/> F <input type="checkbox"/>				

Drug Allergies

 please check the appropriate box(es) where a drug allergy is known.

	CARDHOLDER	SPOUSE	DEPENDENT	DEPENDENT	DEPENDENT
No known allergies	<input type="checkbox"/>				
Erythromycin	<input type="checkbox"/>				
Penicillin	<input type="checkbox"/>				
Codeine	<input type="checkbox"/>				
Aspirin	<input type="checkbox"/>				
Sulfa	<input type="checkbox"/>				
Other	_____	_____	_____	_____	_____

Disease States

 please check the appropriate box(es) for known medical conditions.

	CARDHOLDER	SPOUSE	DEPENDENT	DEPENDENT	DEPENDENT
No known diseases	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>				
Thyroid	<input type="checkbox"/>				
High blood pressure	<input type="checkbox"/>				
Asthma	<input type="checkbox"/>				
Glaucoma	<input type="checkbox"/>				
Epilepsy	<input type="checkbox"/>				
Other	_____	_____	_____	_____	_____

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 CHILDPROOF 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	
<input type="checkbox"/> Credit Card – You authorize Costco Mail Order Pharmacy to charge your credit card to pay for each pharmacy order. Costco will charge your card the total amount of your purchase on or after the date your order ships. This authorization will remain in effect until terminated by you by contacting us at the telephone number or address listed below.				
<input type="checkbox"/> American Express®	<input type="checkbox"/> Costco Credit Card	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover
/ / / /				
NAME AS IT APPEARS ON CARD	CARD NO.	EXP. DATE (MM/YY)		

Voided Check – Enclose a blank check marked “void.” You authorize Costco Mail Order Pharmacy to initiate withdrawals using Electronic Fund Transfers (EFTS) on this check’s account to pay for each pharmacy order and you agree to keep sufficient funds in your account to cover all such orders. Costco Pharmacy will initiate an EFT in the total amount for your purchase on or after the date your order ships. This authorization will remain in effect until terminated by you by contacting us at the telephone number or address listed below.

Checking Savings (Indicate type of account on which check is drawn).

Written Check – If paying by check, you must make payment **in full** and each payment must be received at the time you place your order. When you provide a check as payment, you authorize us to either submit your check for payment or use information from your check to make a one-time electronic funds transfer (EFT) from your account. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your check and you will not receive your check back from your financial institution. Please refer to your prescription plan materials for copay information. **Orders paid by written check take an additional 1 – 2 days to verify funds and could delay processing times.**

Checking Savings (Indicate type of account on which check is drawn).

By signing below, you have made the choice marked above and represent your choice is subject to EFTS laws, regulations and processing and card association rules, and that orders will be fulfilled and shipped only upon receipt of this completed order form and valid payment and/or prescriptions.

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

Standard shipping – (Total process and delivery time: 6 – 14 days) **FREE (USPS)**

3-Day shipping – (Total process and delivery time: 3 – 6 days) **\$10.95 (UPS)***

2-Day shipping – (Total process and delivery time: 2 – 5 days) **\$13.95 (UPS)***

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

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, 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. S.W., Building C, Suite 140, Everett, WA 98204. 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 EnvisionRxOptions and Costco Mail Order Pharmacy. You understand that your prescription medicine order(s) will be fulfilled and shipped upon receipt of your complete order form, the original prescription(s) and applicable payment.

CARDHOLDER SIGNATURE

DATE