

## 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			MI			
SHIPPING ADDRESS (INCLUDE APT. NO. IF APPLICABLE)			CITY	STATE	ZIP	
PHONE NUMBER (INCLUDING ARE	EA CODE)		COSTCO MEMBERSHIP NO. (OPTIONAL)			
YES D NO D						
DO YOU WISH TO RECEIVE EMAIL	REFILL AND RENEWAL REN	/INDERS?	EMAIL ADDRESS	ò		
INSURANCE INFORMA	TION					
MEMBER ID NO.		RX BIN NO. (SEE YOUR	PRESCRIPTION ID CARD)	C	GROUP NO.	
POLICYHOLDER NAME			POLICY HC	DLDER DATE OF BIRTH (MM)	/DD/YYYY)	
HEALTH PROFILE Please	fill in the appropriate box(e attach a separate sheet w		r of the family that is cover	red. If additional space is ne	eeded,	
picase	CARDHOLDER	SPOUSE	DEPENDENT	DEPENDENT	DEPENDENT	
LAST NAME						
FIRST NAME						
MIDDLE INITIAL						
DATE OF BIRTH (MM/DD/YYYY)						
EMAIL ADDRESS (OPTIONAL)*						
SEX	M D F D	M 🗆 F 🗆	M D F D	M D F D	M D F D	
Drug Allergies Please check	the appropriate box(es) w	here a drug allergy is know	n.			
	CARDHOLDER	SPOUSE	DEPENDENT	DEPENDENT	DEPENDENT	
No known allergies						
Erythromycin						
Penicillin						
Codeine						
Aspirin		_				
Sulfa						
	<b>J</b>	J	_	_		
Other						
Modical Conditions Bloom	o abaalitha appropriata ba	y(aa) far known madiaal as	l anditions	I	1	
Medical Conditions Please						
No known diseases						
Diabetes		<u> </u>				
Thyroid						
High blood pressure						
Asthma						
Glaucoma						
Epilepsy						
Other						

FORM CONTINUED ON REVERSE

<sup>\*</sup>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.									
	<b>IS</b> – Please select a payr heck here if same as ship		provide the requested info	ormation:					
BILLING ADDRESS (INCLUD	DE APT. NO. IF APPLICABLE)		CITY	STATE	ZIP				
	authorize Costco Mail Ord ge dates and amounts wil		your credit card to pay for	each pharmacy order.					
⊒ Visa®	☐ MasterCard	☐ Discover							
NAME AS IT APPEARS ON	CARD		CARD NO.		EXP. DATE (MM/YY)				
*UPS will not deliver on week Calculated total proces	Average process and deli ends and cannot ship to P.O. Box is and delivery time starts ication and may vary dep	res.  s once the order is first	received at the pharmacy.	Shipping prices may be s	subject to change				
☐ You have included you ☐ You have provided vo ☐ Your name, address, ☐ You have attached a  ADDITIONAL INFO Please send only presonable form and your presonable forms	DRMATION: riptions to be ordered improprietion(s) at our facility. and prescription(s) to:	cion prescription(s) for a g information. of birth are included or onal dependent inform mediately. We will not h	a 90-day supply.  In all documents including yation or additional instruct  Inold your prescriptions. You  Harmacy, 260 Logistics A  Order Pharmacy at 1-80	ions. ur order should arrive 14  Ave., Suite B, Jefferson	•				
prescription drug histor		co Mail Order Pharmacy	, and authorize release of a y. I understand that my pres d applicable payment.						
^ARDHOLDER SIGNATURE	:		DATE						