

Insurance Cardholder's Date of Birth

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

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 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 insurantee added to the mailing charges. YES	NAME:	DATE			
PHONE #	Patient / Student #	Patient Birth Date			
PAYMENT METHOD VISA MC Please remember to update your credit card before expir 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 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. MES NO	ADDRESS:				
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