

## Mail Service Registration Pharmacy

**Instructions:** Fill out this form completely. Print legibly using black ink only. Use a separate sheet for each patient.

Mail form to: Mayo Clinic Pharmacy Mail Service

21 Second Street SW, Suite 2-20, Rochester, MN 55902

**Or fax form to:** 507-284-5824

If you have questions about completing this form, call the Mayo Clinic Pharmacy Mail Service at 507-284-4041 or toll-free at 1-800-445-6326.

Patient Information	J-0320.			as an antibiotic for an infection) should be filled at your local pharmacy.
Patient Name (First, Middle, Last)				If you have a Mail Service Registration form on file, prescriptions for you received by the Mail Service will be automatically processed and shipped according to your
Birth Date (Month DD, YYYY) Se	x □ Male □ Female	Mayo Clinic Number (	if available)	If you have a Mail Service Registration form on file, prescriptions for you received by the Mail Service will be automatically processed and shipped according to your registration information.    If you wish to have a prescription held on your profile and filled at your request at a later date, indicate by writing "FILE" on the prescription.    When a prescription medication is available as a generic, the generic will be dispensed unless otherwise designated by the prescriber. Some medications are available only as a brand name.    By law, Mayo Clinic Pharmacy cannot accept returns of prescription medications for credit or reuse.    You must have a valid credit card (VISA, MasterCard, Discover, or American Express only).    New prescriptions or authorization for additional refills that are faxed must be sent by the prescriber and cannot be faxed by a patient.    If you wish to estimate your pharmacy copayment before placing an order, contact your pharmacy benefit manager as indicated on your membership card.    Subscriber Relationship to Patient   Self   Spouse   Child   Other:    RxGroup:
Medication Allergies  ☐ None ☐ Aspirin ☐ Code ☐ Other (specify):	ine 🗆 Penicil	lin □ Sulfa □	☐ Tetracycline	When a prescription medication is available as a generic, the generic will be dispensed unless otherwise designated by th
Medical Conditions  ☐ None ☐ Diabetes ☐ Epilepsy ☐ Glaucoma ☐ Hypertension ☐ Ulcer ☐ Heart Condition ☐ Other (specify):				name.  • By law, Mayo Clinic Pharmacy cannot accept returns of
Contact Name (for questions about this or	der)	Contact Phone		You must have a valid credit card (VISA, MasterCard, Discover)
Email (for notification)				<ul> <li>New prescriptions or authorization for additional refills that a faxed must be sent by the prescriber and cannot be faxed by</li> </ul>
Authorization Signature				
I accept the terms and conditions and	wish to register fo	r Mail Service.		
Signature (required)		Date (Month DD, YYYY)		
Insurance and Subscriber In	formation			
Insurance Company Name		Company Ph	one	☐ Self ☐ Spouse ☐ Child
Subscriber/Identification Number	Pharmacy RxBin:	Coverage Information	RxPCN:	RxGroup:
Detient Desistration Informs				
Patient Registration Informa Shipping Address	tion	ı		
City	State	ZIP Code	Daytime Phone (with area code)	
Payment Information				
FSA or HSA Card Type	Master Card	□ Discover □ An	nerican Express	Cardholder Name (print name as it appears on card)

Card Number

Cardholder Signature

Expiration Date (MM, YYYY)

Date (Month DD, YYYY)

Read: Important information about mail service terms

information may cause delivery to be delayed beyond ten days.

No shipping or handling charges apply to orders shipped via

U.S. Mail. Overnight shipping is available; charges will apply. Mail Service is appropriate for long-term maintenance

prescription drugs. Prescriptions for medications that are

• Allow 7-10 business days for delivery. Incomplete

and conditions