



# Free Home Shipping New Rx Order Form

- Please complete this form and mail it to us at the address below with your original, prescriber-signed prescription(s).
- If you wish to fill prescriptions for multiple patients, please fill out multiple forms.
- You will be notified if extra processing time is required for prescriptions that need prescriber clarification.
- For refills or any additional services, please visit: [www.wegmans.com/pharmacy](http://www.wegmans.com/pharmacy) or call 1-800-934-4797

Mail this form to: **Wegmans Pharmacy Free Home Shipping**  
 P.O. Box 64472  
 Rochester, NY 14624

## Patient Information:

First Name	MI	Last Name	Suffix	Date of Birth (MM/DD/YYYY)	
	█	█	█	/ /	
Permanent Address					
City				State	Zip Code
				█	█
Email Address (for shipping notification)				Preferred Phone Number	
				( )	
Check one: <input type="radio"/> Home <input type="radio"/> Cell					

Gender:  Male  Female      Drug Allergies:  None  Codeine  Penicillin  Aspirin  Sulfa  Other: \_\_\_\_\_

## Insurance Information:

Rx BIN	Rx PCN	Cardholder ID	Rx GRP
	█	█	█

Relationship to Cardholder:  
 Cardholder  Spouse  Child

## Shipping Information:

Delivery Method:  Standard (5-10 business days): No Charge       Express (1-2 business days): \$18.95

Shipping Address (only if different than permanent address)

					State	Zip Code
					█	█

**Prescriptions:**

---

MD	MD Phone #		MD Address	
	Select One:		Select One:	
Drug Name/Strength	I will include this prescription with this form	Please contact my doctor for this prescription	Fill Now	Place on hold for later fill
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

MD	MD Phone #		MD Address	
	Select One:		Select One:	
Drug Name/Strength	I will include this prescription with this form	Please contact my doctor for this prescription	Fill Now	Place on hold for later fill
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

