RMB Pharmacy Delivery/Mail Order Registration Form

(Please fill out sections of the form. Failure to do so will delay processing)

PATIENT INFORMATION

NAME: _____
(Last) (First) (Middle)

GENDER: ❑ Male ❑ Female DATE OF BIRTH: _____/_____/_____

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME: (____)_____ CELL: (____)_____ WORK: (____)_____

ALLERGIES: ❑ None Known ❑ Penicillin ❑ Sulfa ❑ Codeine ❑ Others: _____.

OhioHealthy INSURANCE INFORMATION

Name of Cardholder:_____Member ID: _____ Clock # _____

Family members also covered: (Payment information below will apply for all members listed)

Name: _____ DOB: ____/____/____ Allergies: _____

Name: _____ DOB: ____/____/____ Allergies: _____

Name: _____DOB: ____/____/____ Allergies: _____

Name: _____ DOB: ____/____/____ Allergies: _____

DELIVERY INFORMATION

❑ **Mail to Home**

❑ **Deliver by Courier (fill out sections 1&2 below:)**

1. ❑ Doctors ❑ Dublin Methodist ❑ Grady ❑ Grant ❑ 180 E. Broad ❑ 155 E. Broad
   ❑ Preserve 1 ❑ Preserve 2 ❑ Preserve 3
2. Please List Your Department: _____

PAYMENT INFORMATION

I, _____, (full name) authorize OhioHealth to charge/deduct the ***Patient Responsibility*** for prescriptions filled at RMB Pharmacy, as determined by the OhioHealthy Medical Plan, for prescriptions submitted at my request up to ***$100***. Approval is required prior to processing charges/deductions exceeding the aforementioned amount. All prescriptions sales are ***non-returnable*** and ***non-refundable*** once no longer in the possession of the pharmacy, or authorized agent.

_____ _____
(Signature) (Today's Date)

Payment Method: (Please select one below. If there are issues with the payment option selected below, you will be contacted, this may also delay order processing.)

❑ **Flex Spend Account:** (By checking this box, I assign my insurance benefits to the provider listed above. I understand this form is valid for RMB purchases only. I can cancel the authorization through written notice to RMB Pharmacy.)

Benny Card # _____ Exp. Date: _____

3-digit Security Code on Back of Card: _____

_____ _____
(Cardholder's Signature) (Today's Date)

❑ **Payroll Deduct:** Clock #_____ **(Participation will be discontinued upon termination. Remaining amounts due will be deducted from final paycheck)**

❑ **Credit Card:**

❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

Credit Card # _____ Expiration Date: ____/____/____

_____ _____
(Cardholder's Signature) (Today's Date)

Phone: (614)566-5115 RMB Fax: (614)566-6999