GRAND RONDE PHARMACY

MAIL ORDER REGISTRATION FORM

Person Code_____

1. **PLAN MEMBER Name: _____Nasomah Health Card ID #_____**

   This Registration is for - PLEASE MARK ONE:

   ☐ **Plan Member** ☐ **Spouse** ☐ **Dependent Child**

   Name_____

   Last First Middle

   Home Address:_____

   Street City State Zip

   Mailing Address (if different):_____

   Street or PO Box City State Zip

   County of Residence:_____ Date of Birth_____ Male___ Female____

   Month / Day / Year

   Home Phone: (____)_____-_____ Cell phone# (_____)_____-_____Social Security#_____

   Member of Federally Recognized Tribe: Yes___ No ___ Tribe_____ Roll#_____ Blood Quantum_____

   Drug Allergies: No___ If Yes (please list) _____

   Local Pharmacy currently dispensing medications:_____

2. **Payment Method:** Standard delivery of your order is free. To expedite shipping, you may choose to have your order sent by next-day UPS at your expense. Your copay in accordance with your plan benefits (and any expedited shipping at your request) will be charged to your credit card at the time of shipment. All future orders will be charged to this credit card. Orders will not be shipped without proper payment.

   ☐ **Please call for payment**

   ☐ **Credit Card #_____Expiration Date_____**

   Month/Year

   Cardholder Name (as appears on card)_____

   Billing Zip Code_____; Authorized Signature for credit card_____

3. **I would like my prescriptions dispensed with NON CHILD resistant (easy open) lids: Yes _____ No _____**

4. **I request that this and future orders be shipped "signature required" for an additional charge: Yes _____ No _____**

5. **I certify that all the information on this form is correct, including any selections made for sending my order signature required or with non child resistant (easy open) caps and authorize Grand Ronde Pharmacy to dispense and mail prescriptions according to the parameters of my prescription plan and the information I have provided on this form. I am responsible for notifying Grand Ronde Pharmacy of any changes to my personal information in order to assure proper delivery and filling of my prescriptions.**

_____

Authorized Signature **Date**