

Verified and Checked by _____ **PLAN YEAR 2011 – 2012** Registration Update YES / NO



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**

NAME: _____ DATE _____

Patient / Student # _____ Patient Birth Date _____

ADDRESS: _____

PHONE # _____ EMAIL ADDRESS _____

INSURANCE ID OR SSN # _____

PAYMENT METHOD



Please remember to update your credit card before expiration

CREDIT CARD # _____ EXP DATE: _____ V-CODE _____

1. Do you have insurance other than **UW health insurance** (i.e. as a dependent on a spouse's or parents' plan)? YES / NO
Note: the GAIP insurance is a secondary plan. If you checked "Yes", you must bill your primary insurance plan first then self submit the co-pay to the UW insurance plan.
2. Have you been continuously covered by a **UW insurance plan** for the last 90 days? YES / NO
Note: the UW insurance plan may exclude benefits for the existence of symptoms within the 3 months immediately prior to the Insured's Effective Date under the policy. Please refer to your insurance booklet for eligibility, coverage, and exclusions.
3. Any changes to the insurance plan must be updated with the pharmacy **immediately** so that the correct insurance will be billed.

By signing this form, I understand that, if my claim is rejected by WPAS, **I am financially responsible for any rejected amounts** and any service fees or late charges. The "Explanation of Benefits" (EOB) from WPAS will be the only notice of rejection. No additional notifications will be sent from the pharmacy. If I fail to pay the balance due at the pharmacy within thirty days after WPAS sends the EOB, the rejected amounts plus any service or late charges will be posted on my Student Account. Delayed payment may cause the account to be sent to a Collection Agency.

*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 RA/TA insurance or 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. YES / NO

I _____ authorize the Hall Health Center Pharmacy to process and charge my insurance policy and credit card for my prescription(s) including all monies owed by me for the prescriptions and the mailing fees as determined.

*Signature _____ Date _____

I have read and agree to the statements made in the Mailing Agreement and agree to abide by them.

Print Name _____ Signature _____ Date _____

For **Dependent Patients**, please complete the following

Insurance Cardholder _____ Cardholder's Student # _____

Insurance Cardholder's Date of Birth _____