ECU PHARMACY SERVICES
REGISTRATION for DELIVERY

Name: _____ Date of Birth: _____

Home Address: _____ City: _____
State: _____ Zip: _____

Home Phone: _____ Work Phone: _____
Email Address: _____
Allergies: _____
Insurance - Attach a copy of insurance card if possible
Insurance ID: _____ Group #: _____ Bin #: _____

Must Check One:
☐ Others can sign for deliveries on my behalf
☐ I prefer to sign for all deliveries

Fax: 252-744-1800
Phone: 252-744-2721

Additional Family Members (Call or Email Pharmacy with Family Members Allergies):

Name	Date of Birth	Relationship

ECU Delivery Address: _____

Indicate whether you prefer to call & request delivery or to have ECU Pharamacy Services automatically deliver when a prescription is phoned in by a provider or a refill is requested through any automated service or by phone. Note: The ECU Pharmacy Services delivery personnel cannot take back medications once accepted.

Automatically Deliver ☐ I will call and request delivery ☐

FORM MUST BE FAXED OR DELIVERED IN PERSON. DO NOT EMAIL.

My signature below authorizes ECU Pharmacy Services to charge the credit/debit card, also provided below, for my prescription purchases and to deliver my prescriptions to the address provided above following the date on this form. I also understand that the debit/credit card information I provided will be physically stored on site and will be destroyed securely upon one of the following: my request to terminate delivery, providing a revised form or upon expiration of this form which is one (1) year from today. It is my responsibility to submit a new registration form to ECU Pharmacy Services if I desire to update/change anything on this form. It is also my responsibilty to notify ECU Pharmacy Services in writing if I desire to terminate services altogether.

Credit/Debit Card Number: _____ Exp Date _____
Security Code on Back: _____
Name as it appears on card: _____

Signature: _____

Date: _____