My Meds by Mail Program Registration Form

My Meds by Mail Program Managed by Metro Pharmacy: 20 Church Avenue, North York, ON M2N 0B7	Phone Number:	Toll Free:**1-855-382-1613**
	Fax Number:	Toll Free: **1-855-821-0950**

Please Note: All particpants must provide the My Meds by Mail program with a signed copy of the Terms & Conditions form

Last Name	First Name	Date of Birth (Month/Day/Year)	Gender
			Male/Female

Mailing Address	City	Postal Code

Home Phone Number	Cell Phone Number	Work Phone Number	Daytime Contact Number
( ) -	( ) -	( ) -	( ) -

Medication Allergies

Do you suffer from any medication allergies?

Yes / No

If Yes, please describe nature of reaction

Medication	Reaction (i.e. hives, rash)
1)	
2)	
3)	
4)	
5)	

Insurance Information

How do you receive reimbursement for prescriptions? (Select one)

1) Pharmacy submits online at 2) You pay first and then submit claim

Cardholder Last Name	Cardholder First Name
Insurance Company (i.e. ESI,GS)	Carrier Identification (member ID)
Group Number (Contract/Policy Number)	Certificate Number

Phone/Fax Physician Request

Would you like us to contact your physician for a refill on your prescriptions? Yes / No

Physician Name	
Physician Phone Number	( ) -
Physician Fax Number	( ) -
Medications you would like refilled	1)
	2)
	3)
	4)

Prescription Transfer Request

Would you like us to contact your current pharmacy to transfer your prescriptions ? Yes / No

Pharmacy Name	
Pharmacy Phone Number	( )
Pharmacy Fax Number	( )
Medications you would like transferred	1)
	2)
	3)
	4)

Would you like to enroll in the Refill Reminder Program? Yes / No