RXDN P.O. BOX 65681 Philadelphia, PA 19155
Tel: 1-800-800-8769 Fax: 215-785-2923 www.rxdn.com

Pharmacy Member Profile Form

This form is for new members to establish initial data in our system. Please complete this form and return to us by mail or fax.

- **Primary card holder Profile:**

Last Name:________________________________ M.I.: ________ First Name: _______________________________

Date of Birth: _______________________ Sex: M_____ F_____

E-mail Address: ____ Safety cap required: Yes_______ No_______

Delivery Address: ____

Billing Address: ____

Home Phone#: __________________ Work Phone#: ______________________ Cell Phone#: __________________

Prescription Plan Group#: ___________________PCN#_____________BIN#:____________

Card ID#: __________________________________

Drug allergies: ____

- **Eligible family members' profiles:**

Name: ____ D.O.B: ___________________ Sex: M_____ F____

Drug Allergies: ____________________________________ Relationship to card holder: ___________

Name: ____ D.O.B: ___________________ Sex: M_____ F____

Drug Allergies: ____________________________________ Relationship to card holder: ___________

Name: ____ D.O.B: ___________________ Sex: M_____ F____

Drug Allergies: ____________________________________ Relationship to card holder: ___________

Please use the back of this form for additional family members.

- **Payment information:**

Pay by credit card- VISA, MASTER, AMEX, & DISCOVER and debit cards with VISA or MASTER

Type of credit card: _______ Credit card#: _____________________________________ Exp date: ________

Security#_______________ Authorized Signature: ____

I HEREBY CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT AND I HAVE READ THE NOTICE OF PRIVACY PRACTICES. I AUTHORIZE RELEASE OF ALL INFORMATION TO RXDN. I ALSO AUTHORIZE RXDN TO USE ABOVE CREDIT CARD(S) TO PAY FOR MY MEDICATION ORDERS.

Card holder's Signature: ____ Date: ______________________