Complete and print.

Reset Form

MAYO CLINIC

Mail Service Prescription Transfer Request

Pharmacy

Form content not retained in medical record. **Discard after use.**

Instructions: Print legibly using black ink only. If you have additional prescriptions, use another form. Use a separate form for each patient.

Mail to: Mayo Clinic Pharmacy Mail Service RO_TF_1-300
200 First Street SW, Rochester, MN 55905

Or fax to: 507-284-5824

If you have questions about completing this form, call the Mayo Clinic Pharmacy Mail Service at 507-284-4041 or toll-free 1-800-445-6326.

Patient Information

Patient Name (First Middle Last)		Birth Date (mm-dd-yyyy)
Mayo Clinic Number (if available)	Legal Sex ☐ Female ☐ Male ☐ Nonbinary ☐ Unknown	
Medication Allergies ☐ None ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other, specify:		
Medical Conditions ☐ None ☐ Diabetes ☐ Epilepsy ☐ Glaucoma ☐ Hypertension ☐ Ulcer ☐ Heart condition ☐ Other, specify:		
Contact Name (for questions about this order) (First Middle Last)	Contact Phone	Other Medications You Are Taking

Important information about mail service terms and conditions:

- **Allow 7 to 10 business days for delivery**. Incomplete information may cause delivery to be delayed beyond 10 days.
- No shipping or handling charges apply to orders shipped via U.S. Mail. Overnight shipping is available; charges will apply.
- Mail Service is appropriate for long-term maintenance prescription drugs. Prescriptions for medications that are needed immediately and/or for a one-time treatment (such as an antibiotic for an infection) should be filled at your local pharmacy.
- If you have a Mail Service Registration on file, prescriptions for you received by the Mail Service will be automatically processed and shipped according to your information.
- Generic medications will be dispensed unless otherwise designated by the prescriber (some medications are available only as a brand name).
- By law, Mayo Clinic Pharmacy cannot accept returns of prescription medications for credit or reuse.
- You must have a valid credit card (Visa, Mastercard, Discover, or American Express only).
- New prescriptions or authorization for additional refills that are faxed, must be sent by the prescriber and cannot be faxed by you, the patient.
- If you wish to estimate your pharmacy copayment before placing an order, contact your pharmacy benefit manager as indicated on your membership card.

Authorization Signature Sign here **only** if you are not currently registered.

I accept the terms and conditions and wish to register for Mail Service.	Signature (required) ▶ Signature Required	Date (mm-dd-yyyy)

Insurance and Subscriber Information Complete **only** if you are not currently registered.

Insurance Company Name	Company Phone	Subscriber Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other:
Subscriber/Identification Number	Pharmacy Coverage Information RxBin: RxPCN: RxGroup:	

Patient Registration Information Complete **only** if you are not currently registered.

Shipping Address	City	State	ZIP Code
Email	Daytime Phone (with area code)		

Prescription Information If you wish to have a prescription held on your profile and filled at your request at a later date, check "file only."

Outside Pharmacy Name and Address (Street, City, State, ZIP Code)	Outside Pharmacy Phone

Rx Number	Fill or File	Drug Name and Strength	Prescriber Name	Current Directions on Label
	☐ Fill now ☐ File only			
	☐ Fill now ☐ File only			
	☐ Fill now ☐ File only			

Payment Information Complete **only** if you are not currently registered. Credit card information is securely shredded after office use.

FSA or HSA? ☐ Yes ☐ No	☐ Visa ☐ Mastercard ☐ Discover ☐ American Express	Card Number	CVV No.	Expires (mm/yyyy)	Print Cardholder Name (as it appears on card)

Print