



It's easy. Just complete this form, attach the original prescription(s), and mail it to us at the address shown below.

Patient name:	Daytime phone number:
8-digit ID from member card: <input type="text"/>	Is it OK to leave a detailed message? YES <input type="checkbox"/> NO <input type="checkbox"/>
Current pharmacy name:	Current pharmacy phone number:
Personal (primary care) doctor's name:	Doctor's phone number:
Prescriber (if other than personal doctor):	Prescriber's phone number:

**Order now** – Check this box and give us the information requested below. Your order should arrive within seven business days. You will be billed separately. *In order to protect your security, please do not send bank card information with your order.*

**Shipping information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

**Order later** – Check this box and we'll set up our system so you can order online through [kp.org/wa](http://kp.org/wa).<sup>\*</sup> Or use our automated telephone system at 1-800-245-7979.

<sup>\*</sup>ID verification required to use enhanced services on the member website.

Additional instructions for the pharmacy:

Please mail this form and ORIGINAL prescription to:

Kaiser Foundation Health Plan of Washington  
Mail Order Pharmacy  
P.O. Box 34383  
Seattle, WA 98124-1383