Date: [Insert Date]

To: [Pharmacy Name]
Address: [Pharmacy Mailing Address]
City, State, Zip: [City, State, Zip Code]

Subject: Authorization for Mail-Order Prescription Delivery

To Whom It May Concern,

I, [Patient Full Name], born on [Date of Birth], hereby authorize [Pharmacy Name] to fill and deliver my prescriptions via mail to the address provided below.

Member/Policy ID: [Insert ID Number]
Group Number: [Insert Group Number]

Shipping Address:
[Street Address / Apartment Number]
[City, State, Zip Code]
Phone Number: [Insert Phone Number]

Prescription Information:
Please process the following medication(s):
1. [Medication Name and Strength]
2. [Medication Name and Strength]

Payment Authorization:
I authorize [Pharmacy Name] to charge any applicable copayments or shipping fees to the credit card on file or the payment method provided during the enrollment process.

Please notify me immediately if there are any issues with insurance coverage or if a signature is required upon delivery.

Sincerely,

[Signature]

[Printed Name]