Registration & Prescription Order Form

Member Information (Required)

Primary Cardholder Name: ______________________________
First / Middle Initial / Last

Address: ______________________________
Street (do not use P.O. Box) / Suite or Apt # / City / State / Zip

( ) Daytime Phone

( ) Evening Phone

Date of Birth: __ / __ / ____
MM DD YYYY

Female: ☐ Male: ☐ Email Address: ______________________________
Optional

Doctor's Name: ______________________________
First / Last

Dr.'s Phone: ______________________________

☐ Patient needs snap-on caps
☐ Patient needs Spanish vial labels

Allergies:
☐ 32-Codeine ☐ 70-Penicillin ☐ 87-Sulfa ☐ 93-Tetracycline ☐ No known allergies
☐ Other (list): ______________________________

Health Conditions:
☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma
☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ No known health conditions
☐ Other (list): ______________________________

Employer and Prescription Coverage Information

Prescription Benefit Provider/
Pharmacy Drug Insurance: ______________________________

Your Employer Name: ______________________________ ☐ Active ☐ Retiree

Member ID Number (from ID Card):

Group Number:

Please Note: By submitting this form, you have authorized release of all information to Walgreens Mail Service (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan. Thank you for your order.
Please allow two weeks for delivery.

Please complete both pages →

119

DEPENDENT INFORMATION (Print additional pages if you have coverage for multiple dependents)

Be sure to complete Member Information section

Dependent Name: ______________________________
First Middle Initial Last

Address: ______________________________
Street (do not use P.O. Box) Suite or Apt # City State Zip

( ) Daytime Phone

( ) Evening Phone

Date of Birth: __ / __ / ____ MM DD YYYY

Relationship to Cardholder: ______________

Female: ☐ Male: ☐ Email Address: ______________ Optional

Doctor's Name: ______________ First Last Dr's Phone: ______________

☐ Patient needs snap-on caps
☐ Patient needs Spanish vial labels

Allergies:
☐ 32-Codeine ☐ 70-Penicillin ☐ 87-Sulfa ☐ 93-Tetracycline ☐ No known allergies
☐ Other (list): ______________

Health Conditions:
☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma
☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ No known health conditions
☐ Other (list): ______________

CREDIT CARD INFORMATION

Credit Card Number: (Visa, MasterCard, Discover)

Credit Card Number: (American Express)

Name as it appears on card: ______________
First Middle Initial Last

Expiration Date: __ / __ / ____ MM DD YYYY

Signature: ______________

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Mail Service will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center at 1-800-345-1985 to advise.

Simply mail your original prescription and this form along with your credit card information or check made payable to:

Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038-9061
Customer Care Center: 1-800-345-1985 (TTY for hearing impaired: 1-800-573-1833)
Refills by Phone: 1-800-RX-REFILL (1-800-797-3345) (en español: 1-800-778-5427)
Internet: www.walgreensmail.com