Walgreens Mail Service Registration & Prescription Order Form

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Your Employer Name: _____

Use this form to register/submit your first prescription order. You can also register at **Walgreens.com/mailservice. DO NOT** staple, tape or paperclip anything to this form.

Please print clearly using only **BLACK INK** and **UPPERCASE** letters. Fill in the applicable circles completely (●). **Not all ID and Group Number boxes may be needed.**

MEMBER INFORMATION

○ Male ○ Female

Date of Birth [MM/DD/YYYY] / /

Prescription Benefit Provider/Pharmacy Drug Insurance: _____

Member ID Number *(Located on card)*

Email Address *(To receive information regarding the processing of your order)*

Suffix *(If on card)*

BIN *(Located on card)*

PCN *(Located on card)*

Group Number *(Located on card)*

Last Name

First Name

Cell Phone – –

Text Msg* ○ Yes ○ No

Permanent Address Line 1

Daytime Phone – –

Permanent Address Line 2

Evening Phone – –

City

State

ZIP Code

Government ID *(Most states require ID for controlled Rx substances by law)†*

Prescriber Last Name

Prescriber First Initial

Prescriber Phone – –

Prescriber Fax – –

MEMBER

Allergies	Health Conditions	Order Preference
○ Aspirin	○ Arthritis	○ Large-print vial labels
○ Cephalosporin	○ Asthma	○ Spanish vial labels
○ Codeine derivatives	○ Diabetes	Automatic refill‡
○ Morphine derivatives	○ Glaucoma	
○ Penicillin	○ Heart disease	*‡Fill in this circle if you would like us to automatically refill your prescriptions in the future.*
○ Sulfa drugs	○ Hypertension	
○ None known	○ Pregnancy	
○ Other *(Use lines below)*	○ Thyroid disease	
_____	○ None known	_____
_____	○ Other *(Use lines at right)*	_____

Payment Options

Payment is required at time of order. Please do not send cash.
We accept American Express®, Discover®, MasterCard® and Visa®.

○ Check made payable to Walgreens

○ Charge credit card below for this order only

○ Place credit card below on file for this and all future orders

Credit Card Number

Expiration Date [MM/YY] /

I authorize Walgreens to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature _____ Date _____

*Standard text message and data rates may apply.

†Driver's license, state ID number, social security number, military ID or passport ID.

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DEPENDENT INFORMATION

○ Male
○ Female

Date of Birth [MM/DD/YYYY] ☐☐ / ☐☐ / ☐☐☐☐

For separate shipping, please contact the Customer Care Center toll free at 800-345-1985.

Dependent Last Name

Dependent First Name

Suffix *(If on card)*

Email address *(To receive information regarding the processing of your order)*

Prescriber Last Name

Prescriber First Initial

Prescriber Phone ☐☐☐–☐☐☐–☐☐☐☐

Prescriber Fax ☐☐☐–☐☐☐–☐☐☐☐

DEPENDENT

Allergies

○ Aspirin
○ Cephalosporin
○ Codeine derivatives
○ Morphine derivatives
○ Penicillin
○ Sulfa drugs
○ None known
○ Other *(Use lines below)*

Health Conditions

○ Arthritis
○ Asthma
○ Diabetes
○ Glaucoma
○ Heart disease
○ Hypertension
○ Pregnancy
○ Thyroid disease
○ None known
○ Other *(Use lines below)*

Order Preference

○ Large-print vial labels
○ Spanish vial labels
Automatic refill*

**Fill in this circle if you would like us to automatically refill your prescriptions in the future.*

ORDER INFORMATION *If including a prescription order, please complete this section.*

Please allow 10 business days from the time that you place your order to receive your prescription(s). A refill order form and return envelope will be included with your shipment.

Generic equivalents are usually less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. ❑ I do not accept a generic equivalent.

By submitting this form, you have authorized release of all information to Walgreens (and other necessary parties) as required to process your order under your benefit plan.

Total number of prescriptions in this order..... ☐☐

Total included for copay(s)..... $ ☐☐☐☐.☐☐

○ Standard Shipping **NO CHARGE**
○ Next Business Day ($19.95†) $ ☐☐.☐☐
○ 2nd Business Day ($12.95†) $ ☐☐.☐☐

Total Payment Due..... $ ☐☐☐☐.☐☐

†*Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.*

Please print your name and date of birth on all prescriptions; enclose them along with this completed form and mail to:

Walgreens
P.O. Box 29061
Phoenix, AZ 85038-9061

WI0288-0316