

Walgreens Mail Service REGISTRATION & PRESCRIPTION ORDER FORM



Please **PRINT** clearly using **UPPERCASE** letters. Use only black ink. Enclose this form with your mail service prescription. A reorder form and envelope will be included with each delivery.

MEDICARE PART D

GROUP NO.:

INTERCOM: **ALBCMPD** UPI: **BCB046** RX BIN

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MEMBER ID NUMBER (VERY IMPORTANT)

SUFFIX 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.

Please complete both pages of this form.

#1 MEMBER INFORMATION		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male		
<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="checkbox"/> Female		
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
HEALTH CONDITIONS: <input type="checkbox"/> No Known <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 500-Glaucoma <input type="checkbox"/> Other (list):		
Dr. Name (print)	Dr. Phone (very important)	
<input type="checkbox"/> Check if patient needs snap-on caps. <input type="checkbox"/> Check if patient needs Spanish vial labels.		

IMPORTANT

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 to advise.

Number enclosed	Cost (ea.)	Subtotal
	\$	\$
	\$	\$
TOTAL AMOUNT ENCLOSED		\$
Please contact your plan sponsor for benefit questions.		

Checks payable to:
Walgreens Mail Service
P.O. Box 628001
Orlando, FL 32862-8001

CUSTOMER CARE CENTER:
1-800-489-2197
(TTY for hearing impaired:
1-800-573-1833)

REFILLS BY PHONE:
1-800-RX-REFILL (797-3345)
(en español: 1-800-778-5427)

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; **no cash, please**)

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CREDIT CARD EXPIRATION

Thank you for your order. Please allow two weeks for delivery from the date you mail your order

