Walgreens Mail Service

## Mail Service Pharmacy Tips

**MAIL REGISTRATION & PRESCRIPTION ORDER FORM**

- New prescriptions must be mailed to Walgreens Mail Service pharmacy.
- For long-term medications you need right away: ask your doctor for two prescriptions–one for a small supply to fill at a participating retail pharmacy and one for a long-term supply to fill through the mail.
- Most orders are shipped by U.S. Postal Service. Controlled substances may require an adult signature upon receipt. Packaging does not show any indication that medications are enclosed.
- Allow 2 weeks for delivery.
- Emergency prescriptions can be shipped overnight. Please call our Customer Care Center.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted.
- Refills cannot be transferred from other pharmacies. Request a new prescription from your doctor.
- Use black ink only. Enclose form with prescription(s) and payment.

**Customer Care Center:**
**1-888-832-5462** (TTY: 1-800-573-1833)
Monday–Friday: 8:00 a.m.–10:00 p.m. (Eastern)
Saturday–Sunday: 8:00 a.m.–5:00 p.m. (Eastern)

**Refills by Phone:**
**1-800-RX-REFILL (1-800-797-3345)**
(en español: 1-800-778-5427)

**Internet:**
**www.walgreensmail.com**

**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.

Cut here

Cut here

# Prescription Drug Program

173000REGENREG001

RxBIN _____ RxGroup _____ (if on ID card)

RxPCN _____ Plan Name _____ (if on ID card)

MEMBER INFO. ☐ Male ☐ Female — Suffix extension if on ID card — ☐ Patient needs snap-on caps ☐ Patient needs large print labels

ID Number (Important-copy from ID card)

Name (First, Last) — Date of Birth (MM/DD/YYYY)

Shipping Address (Please do not use P.O. Box) — Daytime Phone ( )

City — State — ZIP Code — Evening Phone ( )

E-mail Address — Dr. Name — Dr. Phone (Required) ( )

**ALLERGIES:** ☐ No Known ☐ 32-Codeine ☐ 70-Penicillin ☐ 87-Sulfa ☐ 93-Tetracycline ☐ Other (list):

**HEALTH CONDITIONS:** ☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma ☐ 600-Stomach disorders ☐ 700-Thyroid disease ☐ 800-Arthritis ☐ Other (list):

**PAYMENT - CHECK OR CREDIT CARD (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS)**

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.

Credit Card Number

Credit Card Expiration (MM/YY) — Signature (for credit card)

Mail to : Walgreens Mail Service P.O. Box 29061, Phoenix, AZ 85038-9061

**Please complete both sides of this form.**

F2056/04-08

**#2 DEPENDENT INFORMATION**
☐☐ Suffix extension if on ID card

☐ Male ☐ Female
☐ Patient needs snap-on caps ☐ Patient needs large print labels

Name (First, Last)

Date of Birth (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

Shipping Address (if different than member)

Daytime Phone
( )

City | State | ZIP Code

Evening Phone
( )

E-mail Address

Dr. Name

Dr. Phone (Required)
( )

**ALLERGIES:**
☐ No known ☐ 32-Codeine ☐ 70-Penicillin
☐ 87-Sulfa ☐ 93-Tetracycline ☐ Other (list):

**HEALTH CONDITIONS:**
☐ No known ☐ 200-Diabetes ☐ 300-Hypertension
☐ 400-Heart disease ☐ 500-Glaucoma ☐ 600-Stomach disorders
☐ 700-Thyroid disease ☐ 800-Arthritis ☐ Other (list):

**#3 DEPENDENT INFORMATION**
☐☐ Suffix extension if on ID card

☐ Male ☐ Female
☐ Patient needs snap-on caps ☐ Patient needs large print labels

Name (First, Last)

Date of Birth (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

Shipping Address (if different than member)

Daytime Phone
( )

City | State | ZIP Code

Evening Phone
( )

E-mail Address

Dr. Name

Dr. Phone (Required)
( )

**ALLERGIES:**
☐ No known ☐ 32-Codeine ☐ 70-Penicillin
☐ 87-Sulfa ☐ 93-Tetracycline ☐ Other (list):

**HEALTH CONDITIONS:**
☐ No known ☐ 200-Diabetes ☐ 300-Hypertension
☐ 400-Heart disease ☐ 500-Glaucoma ☐ 600-Stomach disorders
☐ 700-Thyroid disease ☐ 800-Arthritis ☐ Other (list):