

# 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.



INTERCOM: NHPMA UPI: MEM001

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.

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MEMBER ID NUMBER (VERY IMPORTANT)

Please complete both sides 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 (     )	
<b>ALLERGIES:</b> <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		
<b>HEALTH CONDITIONS:</b> <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.

**PAYMENT** (required at time of order):

Number of Rx's enclosed	Cost (ea.)	Subtotal
	\$	\$
TOTAL AMOUNT ENCLOSED		\$
Signature (for credit card):		

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

**CUSTOMER SERVICE:**  
**1-800-345-1985**  
 (TTY for hearing impaired:  
 1-800-573-1833)

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

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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.**



<b>#2 DEPENDENT INFORMATION</b>		
Name (First, Last)		
E-mail Address		
<b>Date of Birth (MM/DD/YYYY)</b>		<input type="checkbox"/> Male
<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 (      )	
<b>ALLERGIES:</b> <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		
<b>HEALTH CONDITIONS:</b> <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):		
<b>Dr. Name (print)</b>	<b>Dr. Phone (very important)</b>	
	(      )	
<input type="checkbox"/> Check if patient needs snap-on caps.		
<input type="checkbox"/> Check if patient needs Spanish vial labels.		

<b>#3 DEPENDENT INFORMATION</b>		
Name (First, Last)		
E-mail Address		
<b>Date of Birth (MM/DD/YYYY)</b>		<input type="checkbox"/> Male
<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 (      )	
<b>ALLERGIES:</b> <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		
<b>HEALTH CONDITIONS:</b> <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):		
<b>Dr. Name (print)</b>	<b>Dr. Phone (very important)</b>	
	(      )	
<input type="checkbox"/> Check if patient needs snap-on caps.		
<input type="checkbox"/> Check if patient needs Spanish vial labels.		

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