

## Mail Service Registration Form

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Prescription Drug Plan:			391
	/submit your first prescription ord	der. You can also register at WalgreensMailS	Service.com. DO NOT staple, tape or paperclip anything to this form.
Please print clearly us	ing only <b>BLACK INK</b> and <b>UPPE</b>	RCASE letters. Fill in the applicable circles com	npletely (•). Not all ID and Group Number boxes may be needed.
MEMBER INFORMATION	○ Male ○ Female	Date of Birth [MM/DD/YYYY]	
Member ID Number (Located	on card)	Email Address (To receive informatio	n regarding the processing of your order)
Suffix (If on card) BIN (Loca	ated on card) PCN (Located on	card)	Group (Rx Group) Number (Located on card)
Last Name		First Name	Cell Phone Text Msg?* O Yes O No
Permanent Address (Line 1)			Work Phone
Permanent Address (Line 2)			Home Phone
City		State Zip Code Go	vernment ID (Most states require ID for controlled Rx substances by law) <sup>1</sup>
Prescriber Last Name		Prescriber First Initial Prescriber	Phone Prescriber Fax
	MEMBER		Payment Options
Allergies  Aspirin Cephalosporin Codeine derivatives Morphine derivatives Penicillin Sulfa drugs None known Other (use lines below)	Health Conditions  O Arthritis Asthma Diabetes Glaucoma Heart disease Hypertension Pregnancy Thyroid disease None known	Order Preference  Large-print vial labels Spanish vial labels Automatic refill <sup>‡</sup> ‡Fill in this circle if you would like us to automatically refill your prescriptions in the future.  FOR CALIFORNIA PATIENTS: Before Walgreens Mail Service patients must agree in writing or by electronic notice. can turn on Auto Refill for California patients, Enrollment will remain active for one year from the date you selected.	**Please do not send cash** We accept checks and credit cards.  Checks should be made payable to Walgreens Mail Service.  We accept Visa, MasterCard, Discover and American Express.  Please visit WalgreensMailService.com to pay by credit card.  You will need to create an account: Go to Settings & Payment then Payment Methods to enter a credit card number.  You can also call our Customer Care Center for assistance at: 800-345-1985, TTY 800-925-0178
	Other (use lines below)		

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DEPENDENT INFORMA  Dependent Last Name	O Male Date O Female	of Birth [MM/DD/YYYY]  Dependent F	First Name		For separate shipping, please contact the Customer Care Center for assistance at: 800-345-1985, TTY 800-925-0178
Suffix (If on card) Email A	Address (To receive information	n regarding the processir	ng of your order)		
Prescriber Last Name		Prescriber Fi	rst Initial Prescriber Ph	one	Prescriber Fax
			DEPENDENT		
Alle	ergies		<b>Health Conditions</b>		Order Preference
<ul><li>Aspirin</li><li>Cephalosporin</li><li>Codeine derivatives</li><li>Morphine derivatives</li></ul>	<ul><li>Penicillin</li><li>Sulfa drugs</li><li>None known</li><li>Other (use lines below)</li></ul>	O Arthritis O Asthma O Diabetes O Glaucoma	<ul><li>Heart disease</li><li>Hypertension</li><li>Pregnancy</li><li>Thyroid disease</li></ul>	O None known O Other (use lines below)	<ul> <li>○ Large-print vial labels</li> <li>○ Spanish vial labels</li> <li>○ Automatic refill<sup>‡</sup></li> <li>‡Fill in this circle if you would like us to automatically refill your prescriptions in the future.</li> </ul>
Please allow 10 business da Generic equivalents are usually brand and generic price of each By submitting this form, you have Total number of prescriptions	less expensive than brand name drug. If allowed by your prescribe authorized release of all information this order	e your order to receive y drugs. If we dispense a bra er, we will dispense a gener ation to Walgreens Mail Se	your prescription(s). A refund name drug, you may be noted in a contract of the contract of th	responsible for a higher copa	envelope will be included with your shipment syment and/or the difference between the opt a generic equivalent. s your order under your benefit plan.
O Standard Shipping:O Next Business Day (\$19.9 O 2nd Business Day (\$12.95†) Total Payment Due:	\$	\$		ose them along with this Walgreens P.O. Bo	ate of birth on all prescriptions; s completed form and mail to:  Mail Service ox 29061 Z 85038-9061
†Shipping prices may be subject	t to change by carrier without noti	fication and may vary			

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depending upon weight and zone.