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

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

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Please complete both sides of this form.

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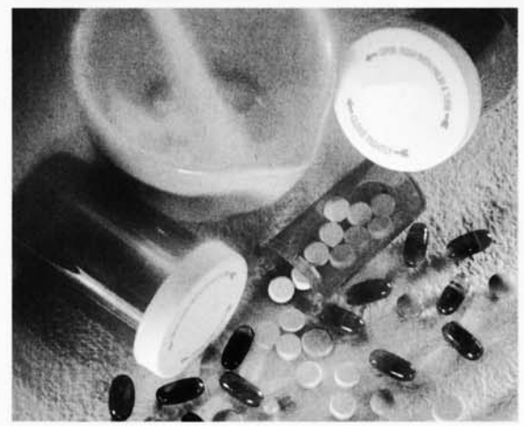
Walgreens Mail Service

Mail Service Pharmacy

New Prescription Order Form



Mail Service Pharmacy Tips

- Complete attached registration form.
- New prescriptions must be mailed to the mail service pharmacy or faxed from your doctor's office on the Walgreens Mail Service doctor fax form.
- 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.
- If two or more prescriptions are sent in for multiple family members, the prescriptions will be shipped, as a single order, to an adult family member at the address given on the order form. If you prefer different shipping arrangements for privacy or other reasons, please contact our Customer Care Center.
- 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.
- Your prescription(s) may be filled for up to the plan days supply maximum when allowed by your physician, the law, and in accordance with pharmacy practice. Some medications may only be dispensed for the exact quantity as written by your physician.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted.
- Allow 2 weeks for delivery.

Customer Care Center:
1-800-745-6285 (TTY: 1-800-925-0178)
Monday–Friday 8:00 a.m. - 8:00 p.m. (Eastern)
Saturday 8:00 a.m. - Noon (Eastern)

Refills by Phone:
1-800-749-0009
(en español: 1-800-758-0002)

Internet:
www.walgreensmail.com

This brochure only highlights your mail service pharmacy benefit. In case of any discrepancy between this brochure and the legal documents describing the plan, the legal documents govern.

BRC6498-1S F1793/02-05

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Please complete both sides of this form.

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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.

1 5 2 0 0 0 C F R S T B C B 0 4 0

INTERCOM: **CFRST** UPI: **BCB040** GROUP NO.: **03000000**

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.

MEMBER ID NUMBER (VERY IMPORTANT - PLEASE DO NOT INCLUDE THE 3 LETTER PREFIX ON THE MEMBER ID CARD)

#1 Member Information

Name (First, Last)

E-mail Address

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

Address (please do not use P.O. Box)

City	State	ZIP Code

Daytime Phone	Evening Phone
( )	( )

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

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

Dr. Name (print)	Dr. Phone (very important)
	( )

☐ Check if patient needs snap-on caps.
☐ Check if patient needs Spanish vial labels.

CUT6687-1S

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.

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 628001
Orlando, FL 32862-8001

CUSTOMER CARE CENTER:
1-800-745-6285
(☎ TTY for hearing impaired: 1-800-925-0178)

REFILLS BY PHONE:
1-800-749-0009
(en español: 1-800-758-0002)

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

CREDIT CARD EXPIRATION

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

F1793/02-05

℞ FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Mail Service

Dr: _____ Dr: _____
DISPENSE AS WRITTEN — SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

℞ FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Mail Service

Dr: _____ Dr: _____
DISPENSE AS WRITTEN — SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

F1793/02-05

FAX ORDER FORM

INTERCOM: CFRST **UPI NO.: BCB 040** 1 0 9

PHYSICIAN: Please fax fully completed form to Walgreens Mail Service: **1-888-595-1258.**
TO THE PATIENT: Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Walgreens Mail Service, P.O. Box 628001, Orlando, FL 32862-8001
Customer Care Center: 1-800-745-6285 (TTY for hearing impaired: 1-800-925-0178)

If you are unable to make an appointment with your doctor, follow these steps to obtain your prescription:

- Fully complete the sections below using **black ink** only.
  A credit card number is required at the time the form is submitted.
- Have your doctor supply the prescription information requested using prescriber's form.
- Have your doctor fax the form to the number above.
  IMPORTANT: To be valid, the prescription must be faxed from your doctor's office.
- Please allow 2 weeks for delivery from the date your physician faxes your prescription in.

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.

MEMBER INFORMATION

ID Number (Please do not include the 3 letter prefix on the member ID card)

Group Number **03000000**

Date of Birth ___/___/___

Name (First, Last)

E-mail Address

Address (please do not use P.O. box)

Daytime Phone ( )

City | State | Zip Code | Evening Phone ( )

PATIENT INFORMATION

Patient Name (First, Last if different from above) | ☐ Male ☐ Female | Patient Date of Birth (Mo/Day/Yr) ___/___/___

Patient E-mail Address

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

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

Dr.'s Name | Dr.'s Phone ( )

PAYMENT INFORMATION

PLEASE NOTE: 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.

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express) CREDIT CARD EXP. ___/___