

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 BLACK INK and UPPE I	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					
Suffix (If on card) BIN (Local	nted on card) PCN (Located on	card)	Group (Rx Group) Number (Located on card)		
Last Name		First Name	Cell Phone Text Msg?* Yes 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) ¹		
Prescriber Last Name		Prescriber First Initial Prescriber	Phone Prescriber Fax		
	MEMBER		Payment Options		
O Aspirin O Cephalosporin O Codeine derivatives O Morphine derivatives O Penicillin O Sulfa drugs O None known O Arthritis O Asthma O Signature O Blaucoma Figure F		Order Preference Large-print vial labels Spanish vial labels Automatic refill [‡] ‡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		
	O Other (use lines below)		255 2.55 1.555, 1.1. 333 325 3113		

^{*}Standard text message and data rates may apply.
†Driver's license, state ID number, social security number, military ID or passport ID.

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DEPENDENT INFORMA	TION	of Birth [MM/DD/YYYY]	1 1		For separate shipping, please contact the Customer Care Center for assistance at: 800-345-1985, TTY 800-925-0178	
Dependent Last Name	endent Last Name Dependent First Name				000-343-1905, 111 000-925-0170	
Suffix (If on card) Email I	Address (To receive information	n regarding the processi	ng of your order)			
Prescriber Last Name		Prescriber F	irst Initial Prescriber Ph	ione	Prescriber Fax	
			DEPENDENT			
Alle	ergies		Health Conditions		Order Preference	
O Aspirin O Cephalosporin O Codeine derivatives O Morphine derivatives	PenicillinSulfa drugsNone knownOther (use lines below)	O Arthritis O Asthma O Diabetes O Glaucoma	O Heart disease O Hypertension O Pregnancy O Thyroid disease	O None known O Other (use lines below)	 ○ Large-print vial labels ○ Spanish vial labels ○ Automatic refill[‡] ‡Fill in this circle if you would like us to automatically refill your prescriptions in the future. 	
Please allow 10 business da Generic equivalents are usually brand and generic price of each By submitting this form, you have	less expensive than brand name of drug. If allowed by your prescribe	e your order to receive your drugs. If we dispense a branch we will dispense a generation to Walgreens Mail Se	your prescription(s). A ref and name drug, you may be ric equivalent unless you che	responsible for a higher copa eck this box.	envelope will be included with your shipment and/or the difference between the ept a generic equivalent. s your order under your benefit plan.	
	·)	NO CHARGE \$		ose them along with this Walgreens P.O. Bo	ate of birth on all prescriptions; s completed form and mail to: Mail Service 2 29061	
•	ct to change by carrier without not	fication and may vary		Prioenix, Az	Z 85038-9061	

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depending upon weight and zone.