



Use this form to register/submit your first prescription order. You can also register at **WalgreensHealth.com**. **DO NOT** staple, tape or paperclip anything to this form.

Please print clearly using only **BLACK INK** and **UPPERCASE** letters. Fill in the applicable circles completely (●). **Not all ID and Group Number boxes may be needed.**

MEMBER INFORMATION		<input type="radio"/> Male <input type="radio"/> Female	Date of Birth [MM/DD/YYYY] <input type="text"/> / <input type="text"/> / <input type="text"/>	Intercom: PHPMN	UPI#: MDP008
Member ID Number <i>(Located on card)</i>	Suffix <i>(If on card)</i>	Group Number			
Email Address <i>(To receive information regarding the processing of your order)</i>					
Last Name	First Name	Cell Phone	Text Msg* <input type="radio"/> Yes <input type="radio"/> No		
Permanent Address Line 1					
Permanent Address Line 2					
City	State	ZIP Code	Government ID <i>(Most states require ID for controlled Rx substances by law)†</i>		
Prescriber Last Name	Prescriber First Initial	Prescriber Phone	Prescriber Fax		

MEMBER			Payment Options				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: black; color: white;"> <th style="padding: 5px;">Allergies</th> <th style="padding: 5px;">Health Conditions</th> <th style="padding: 5px;">Order Preference</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px; vertical-align: top;"> <input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine derivatives <input type="radio"/> Morphine derivatives <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> None known <input type="radio"/> Other <i>(Use lines below)</i> _____ _____ </td> <td style="padding: 5px; vertical-align: top;"> <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Glaucoma <input type="radio"/> Heart disease <input type="radio"/> Hypertension <input type="radio"/> Pregnancy <input type="radio"/> Thyroid disease <input type="radio"/> None known <input type="radio"/> Other <i>(Use lines at right)</i> _____ _____ </td> <td style="padding: 5px; vertical-align: top;"> <input type="radio"/> Large-print vial labels <input type="radio"/> Spanish vial labels <input type="radio"/> Automatic refill ‡ ‡Fill in this circle if you would like us to automatically refill your prescriptions in the future. _____ _____ </td> </tr> </tbody> </table>	Allergies	Health Conditions	Order Preference	<input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine derivatives <input type="radio"/> Morphine derivatives <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> None known <input type="radio"/> Other <i>(Use lines below)</i> _____ _____	<input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Glaucoma <input type="radio"/> Heart disease <input type="radio"/> Hypertension <input type="radio"/> Pregnancy <input type="radio"/> Thyroid disease <input type="radio"/> None known <input type="radio"/> Other <i>(Use lines at right)</i> _____ _____	<input type="radio"/> Large-print vial labels <input type="radio"/> Spanish vial labels <input type="radio"/> Automatic refill ‡ ‡Fill in this circle if you would like us to automatically refill your prescriptions in the future. _____ _____	<p>Payment Options <i>Payment is required at time of order. Please do not send cash.</i></p> <p>We accept American Express®, Discover®, MasterCard® and Visa®.</p> <p> <input type="radio"/> Check made payable to Walgreens </p> <p> <input type="radio"/> Charge credit card below for this order only </p> <p> <input type="radio"/> Place credit card below on file for this and all future orders </p> <p>Credit Card Number <input style="width: 100%;" type="text"/></p> <p>Expiration Date [MM/YY] <input type="text"/> / <input type="text"/></p> <p>I authorize Walgreens to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.</p> <p>Cardholder Signature _____ Date _____</p>
Allergies	Health Conditions	Order Preference					
<input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine derivatives <input type="radio"/> Morphine derivatives <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> None known <input type="radio"/> Other <i>(Use lines below)</i> _____ _____	<input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Glaucoma <input type="radio"/> Heart disease <input type="radio"/> Hypertension <input type="radio"/> Pregnancy <input type="radio"/> Thyroid disease <input type="radio"/> None known <input type="radio"/> Other <i>(Use lines at right)</i> _____ _____	<input type="radio"/> Large-print vial labels <input type="radio"/> Spanish vial labels <input type="radio"/> Automatic refill ‡ ‡Fill in this circle if you would like us to automatically refill your prescriptions in the future. _____ _____					

*Standard text message and data rates may apply.

†Driver's license, state ID number, social security number, military ID or passport ID.



992000PHPMNMDP008

DEPENDENT INFORMATION

- Male
 Female

Date of Birth [MM/DD/YYYY] / /

For separate shipping, please contact the Customer Care Center toll free at 800-745-6289.

Dependent Last Name

Dependent First Name

Suffix (If on card)

Email address (To receive information regarding the processing of your order)

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

 - - - - **DEPENDENT****Allergies**

- Aspirin
 Cephalosporin
 Codeine derivatives
 Morphine derivatives
 Penicillin
 Sulfa drugs
 None known
 Other (Use lines below)

Health Conditions

- Arthritis
 Asthma
 Diabetes
 Glaucoma
 Heart disease
 Hypertension
 Pregnancy
 Thyroid disease
 None known
 Other (Use lines below)

Order Preference

- Large-print vial labels
 Automatic refill*
 Spanish vial labels

*Fill in this circle if you would like us to automatically refill your prescriptions in the future.

ORDER INFORMATION – If including a prescription order, please complete this section.**Please allow 10 business days from the time that you place your order to receive your prescription(s). A refill order form and return envelope will be included with your shipment.**

It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens will dispense an FDA-approved generic equivalent if available, permitted by your prescriber and allowed by state law. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at 800-745-6289.

By submitting this form, you have authorized release of all information to Walgreens (and other necessary parties) as required to process your order under your benefit plan.

Total number of prescriptions in this order..... Total included for copay(s)..... \$

- Standard Shipping **NO CHARGE**
 Next Business Day (\$19.95 †) \$
 2nd Business Day (\$10.95 †) \$

Total Payment Due..... \$ **Please print your name and date of birth on all prescriptions; enclose them along with this completed form and mail to:**Walgreens
P.O. Box 29061
Phoenix, AZ 85038-9061

† Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.