



Use this form to register/submit your first prescription order. You can also register at [Walgreens.com/mailservice](http://Walgreens.com/mailservice). **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**

- Male
- Female

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

Intercom: ALTCR UPI#: ALTO01

Member ID Number (Located on card)  Suffix (If on card)  Group Number

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

Last Name  First Name  Cell Phone  -  -  Text Msg\*  Yes  No

Permanent Address Line 1  Daytime Phone  -  -

Permanent Address Line 2  Evening Phone  -  -

City  State  ZIP Code  Government ID (Most states require ID for controlled Rx substances by law)†

Prescriber Last Name  Prescriber First Initial  Prescriber Phone  -  -  Prescriber Fax  -  -

MEMBER			Payment Options	
<p><b>Allergies</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Aspirin</li> <li><input type="radio"/> Cephalosporin</li> <li><input type="radio"/> Codeine derivatives</li> <li><input type="radio"/> Morphine derivatives</li> <li><input type="radio"/> Penicillin</li> <li><input type="radio"/> Sulfa drugs</li> <li><input type="radio"/> None known</li> <li><input type="radio"/> Other (Use lines below)</li> </ul>	<p><b>Health Conditions</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Arthritis</li> <li><input type="radio"/> Asthma</li> <li><input type="radio"/> Diabetes</li> <li><input type="radio"/> Glaucoma</li> <li><input type="radio"/> Heart disease</li> <li><input type="radio"/> Hypertension</li> <li><input type="radio"/> Pregnancy</li> <li><input type="radio"/> Thyroid disease</li> <li><input type="radio"/> None known</li> <li><input type="radio"/> Other (Use lines at right)</li> </ul>	<p><b>Order Preference</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Large-print vial labels</li> <li><input type="radio"/> Spanish vial labels</li> </ul>	<p><i>Payment is required at time of order. Please do not send cash.</i>  <b>We accept American Express®, Discover®, MasterCard® and Visa®.</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Check made payable to Walgreens</li> <li><input type="radio"/> Charge credit card below for this order only</li> <li><input type="radio"/> Place credit card below on file for this and all future orders</li> </ul>	<p>Credit Card Number <input 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>

\*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 INFORMATION**

- Male  
 Female

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

For separate shipping, please contact the Customer Care Center toll free at 866-352-3230.

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****Health Conditions****Order Preference**

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

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

- Large-print vial labels  
 Spanish vial labels

**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 866-352-3230.

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 †) \$   
 2<sup>nd</sup> 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.

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