



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

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

#3 DEPENDENT INFORMATION		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY)		<input type="checkbox"/> Male
<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="checkbox"/> Female
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
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Please complete both sides of this form.

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