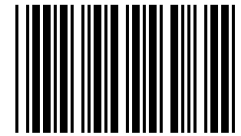




Prescriber Fax Form

Presbyterian Health Plan

Intercom PHS
UPI# PRB001



Please print clearly using only **BLACK INK** and **UPPERCASE** letters.

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Fill in the applicable circles completely (●).

MEMBER OR DEPENDENT: Use this form to have your prescriber submit a medication order or, if you are not yet registered for mail service, you can use this form to register and place your first order. After completing the member and/or dependent, shipping, and payment information, give both pages of the form to your prescriber to complete and fax. Credit card information is required to process your order. **Only faxes sent from a prescriber's office are valid.**

To automatically receive refills of your medications, select Auto Refill. By selecting this option, we automatically refill the prescription(s) at the appropriate time and bill your credit card on file. Most plans allow the convenience of Auto Refill. Check with your plan administrator to see if this is an option for you. As medications may not be returned, if there is a change to your prescription(s), or to discontinue Auto Refill, please notify the Customer Care Center two weeks prior to your next refill date to avoid prescription charges.

PRESCRIBER: Complete the prescription information and fax both pages of the form to **Walgreens Mail Service at 800-332-9581**. Most prescription drug plans allow up to a 90-day supply with three refills.

Subscriber Information

Must be completed for each fax order.

Male Female Date of Birth [MM/DD/YYYY] _____

ID Number (located on card) _____ Suffix (if on card) _____ Group Number PHS _____

Last Name _____ First Name _____ Middle Initial _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP Code _____

Daytime Phone (____) _____ Evening Phone (____) _____

E-mail Address (to receive information regarding the processing of your order) _____

Dependent Information

Complete only if a prescription is included for the dependent.

Male Female

Date of Birth [MM/DD/YYYY] _____

Suffix (if on card) _____

Group Number _____

Last Name _____

First Name _____

Middle Initial _____

E-mail Address (to receive information regarding the processing of your order) _____

Please Complete To Register

Note: If already registered, indicate any changes to member or dependent allergy and health conditions.

		Allergies			Health Conditions
Member	Dependent		Member	Dependent	
<input type="radio"/>	<input type="radio"/>	Aspirin	<input type="radio"/>	<input type="radio"/>	Arthritis
<input type="radio"/>	<input type="radio"/>	Cephalosporin	<input type="radio"/>	<input type="radio"/>	Asthma
<input type="radio"/>	<input type="radio"/>	Codeine derivatives	<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Morphine derivatives	<input type="radio"/>	<input type="radio"/>	Glaucoma
<input type="radio"/>	<input type="radio"/>	Penicillin	<input type="radio"/>	<input type="radio"/>	Heart disease
<input type="radio"/>	<input type="radio"/>	Sulfa drugs	<input type="radio"/>	<input type="radio"/>	Hypertension
<input type="radio"/>	<input type="radio"/>	None known	<input type="radio"/>	<input type="radio"/>	Pregnancy
<input type="radio"/>	<input type="radio"/>	Other (Use lines below)	<input type="radio"/>	<input type="radio"/>	Thyroid disease
		_____	<input type="radio"/>	<input type="radio"/>	None known
		_____	<input type="radio"/>	<input type="radio"/>	Other (Use lines at left)

Order Preference

Easy-open caps Spanish vial labels

Large-print vial labels Auto Refill

