Walgreens Mail Service

Registration and Prescription Order Form

Presbyterian Health Plan

To quickly register, visit www.walgreensmail.com.

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

Fill in the applicable circles completely (●). Not all Group and ID number boxes may be needed.

19100000PHSPRB001

Subscriber Information

○ Male
○ Female

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

Intercom PHS

UPI# PRB001

ID Number (located on card)

Suffix (if on card)

Group Number P H S

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

Daytime Phone – –

Last Name

First Name

Evening Phone – –

Permanent Address 1

Permanent Address 2

City

State

ZIP Code

Prescriber Last Name

Prescriber First Initial

Prescriber Phone – –

Prescriber Fax – –

Dependent Information

○ Male
○ Female

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

Dependent Last Name

Dependent First Name

Suffix (if on card)

Prescriber Last Name

Prescriber First Initial

Prescriber Phone – –

Prescriber Fax – –

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

Please Complete

Member	Dependent	Allergies
○	○	Aspirin
○	○	Cephalosporin
○	○	Codeine derivatives
○	○	Morphine derivatives
○	○	Penicillin
○	○	Sulfa drugs
○	○	None known
○	○	Other (Use lines below.)

Member	Dependent	Health Conditions
○	○	Arthritis
○	○	Asthma
○	○	Diabetes
○	○	Glaucoma
○	○	Heart disease
○	○	Hypertension
○	○	Pregnancy
○	○	Thyroid disease
○	○	None known
○	○	Other (Use lines at left.)

Order Preference

○	○	Easy-open caps	○ ○ Spanish vial labels
○	○	Large-print vial labels	○ ○ Auto Refill*

**only applies if mailing in enrollment form with a prescription enclosed*

19200000PHSPRB001

Subscriber Alternate Shipping Information

If a dependent's medication needs to be delivered to a different address, please submit a separate form. Additional forms are available at www.walgreensmail.com.

○ This shipment only ○ Temporary address change for dates indicated to the right Start Date [MM/DD/YY] __ / __ / __ End Date [MM/DD/YY] __ / __ / __

Alternate Address 1

Alternate Address 2

City State ZIP Code Alternate Phone

Order Information

Please allow 14 days to receive your order.

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Mail Service will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowed by state law.

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

Enclose your prescription with this form. A refill order form and return envelope will be included with your shipment.

Total number of prescriptions in this order .....

Total included for copay(s) .....$.

○ Regular Shipping NO CHARGE
○ Next Business Day ($17.95) $.
○ 2nd Business Day ($10.95) $.

Total Payment Due .....$.

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

Mail to:
Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038-9061

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Payment Options

Payment is required at time of order. Please do not send cash.

○ Check made payable to Walgreens Mail Service
○ Charge credit card below for this order only
○ Place credit card below on file for this and all future orders

We accept American Express®, Discover®, MasterCard®, and Visa®

Credit Card Number

Expiration Date [MM/YY] __ / __

I authorize Walgreens Mail Service 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.

Cardholder Signature _____ Date _____