Walgreens Mail Service Registration & Prescription Order Form

991000AHDOCAHD001

Use this form to register/submit your first prescription order. You can also register at **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: AHDOC **UPI#: AHD001**

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

Allergies	Health Conditions	Order Preference
○ Aspirin	○ Arthritis	○ Large-print vial labels
○ Cephalosporin	○ Asthma	○ Spanish vial labels
○ Codeine derivatives	○ Diabetes	
○ Morphine derivatives	○ Glaucoma	
○ Penicillin	○ Heart disease	
○ Sulfa drugs	○ Hypertension	
○ None known	○ Pregnancy	
○ Other *(Use lines below)*	○ Thyroid disease	
_____	○ None known	_____
_____	○ Other *(Use lines at right)*	_____

AmeriHealth Caritas District of Columbia

*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 800-345-1985.

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
○ 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 a generic equivalent if it's available and permitted by your prescriber. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at 800-345-1985 TTY 800-573-1833.

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..... ☐☐

Standard Shipping **NO CHARGE**

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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