Walgreens Mail Service

Registration and Prescription Order Form
State of Arizona

991000STAZMSAZ001

Use this form to register/submit your first prescription order. You can also register at **WalgreensMail.com/easy.** 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: STAZM **UPI#: SAZ001**

Member ID Number (Located on card)

Suffix (If on card)

Group Number 2 8 9 1 7

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

Last Name

First Name

Permanent Address 1

Daytime Phone – –

Permanent Address 2

Evening Phone – –

City

State

ZIP Code

Prescriber Last Name

Prescriber First Initial

Prescriber Phone – –

Prescriber Fax – –

MEMBER

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 at right)

_____

_____

Order Preference

- ○ Easy-open caps
- ○ Large-print vial labels
- ○ Spanish vial labels
- ○ Automatic refill*

**Fill in this circle if you would like us to automatically refill your prescriptions in the future.*

Payment Options

Payment is required at time of order. Please do not send cash.
We accept American Express®, Discover®, MasterCard® and Visa®.

○ 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

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 _____

992000STAZMSAZ001

DEPENDENT INFORMATION

○ Male ○ Female

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

Visit WalgreensMail.com/easy to set up an online account for dependents. Once registered, you may add a separate shipping address or call our Customer Care Center toll free at 866-304-2846.

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

- ○ Easy-open caps
- ○ Large-print vial labels
- ○ Spanish vial labels
- ○ Automatic refill*

**Fill in this circle if you would like us to automatically refill your prescriptions in the future.*

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 Mail Service 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 866-304-2846.

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.

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

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

- ○ Standard Shipping — NO CHARGE
- ○ Next Business Day ($17.95*) — $☐☐.☐☐
- ○ 2nd 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 Mail Service
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.*

Walgreens Mail Service

Prescriber Fax Form
State of Arizona

Intercom: STAZM
UPI#: SAZ001

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THIS FORM MUST BE FAXED FROM A PRESCRIBER'S OFFICE TO BE VALID.

PATIENT SECTION

Patient: To have your order processed, you must be registered with and have current credit card and shipping information on file with Walgreens Mail Service. You can register online at **WalgreensMail.com/easy** or by mail using the form included in your enrollment kit.

IMPORTANT NOTICE: It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens Mail Service 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 **866-304-2846**.

After you are registered, please print your member ID number listed on your ID card, your phone number and address in the space below and give this form to your prescriber to complete and fax to us.

Member ID Number (Located on card) _____ Patient Phone ____ – ____ – ____

Patient Address _____

City _____ State _____ ZIP Code _____

PRESCRIBER SECTION

Prescriber: Fax this completed form to **Walgreens Mail Service at 800-332-9581. Your signature and date are required.** Most prescription drug plans allow up to a 90-day supply with three refills.

Print and use BLACK INK only. NOT VALID FOR CII PRESCRIPTIONS.

Patient Name _____ DOB [MM/DD/YYYY] _____

	Medication	Strength	Directions	Qty.	# of Refills	DAW
Rx 1						☐
	Medication	**Strength**	**Directions**	**Qty.**	**# of Refills**	**DAW**
Rx 2						☐

Date _____ NPI# _____ DEA# _____
Required for Controlled Substances

Prescriber Signature _____

Prescriber Name (Please print) _____

Prescriber Address _____

City _____ State _____ ZIP Code _____

Prescriber Phone ____ – ____ – ____ Prescriber Fax ____ – ____ – ____ ☐ Check box if this is a new fax number

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