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MAIL SERVICE PHARMACY TIPS MAIL REGISTRATION & PRESCRIPTION ORDER FORM

- New prescriptions must be mailed to Walgreens Mail Service pharmacy.
- 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.
- 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.
- Allow 2 weeks for delivery.
- Emergency prescriptions can be shipped overnight. Please call our Customer Care Center.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted. Payment must accompany order.
- Refills cannot be transferred from other pharmacies. Request a new prescription from your doctor.
- Use black ink only. Enclose form with prescription(s) and payment.

Customer Care Center:

1-866-877-2392 (TTY: 1-800-925-0178)

Monday–Friday 8:00 a.m. - 10:00 p.m. (Eastern)

Saturday–Sunday 8:00 a.m. - 5:00 p.m. (Eastern)

Refills by Phone:

1-800-RX-REFILL (1-800-797-3345)

(en español: 1-800-778-5427)

Internet:

www.walgreensmail.com/medicarerx

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

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Rx BIN 0 0 3 5 8 5

Rx Group _____ (required)

Rx PCN 9 8 6 2 3

Rx Plan Name Prescription Blue _____ (required)

MEMBER INFORMATION
 Male Female Suffix extension if on ID card Patient needs snap-on caps Patient needs large print labels

ID Number (Important-copy from ID card) [] [] [] [] [] [] [] [] [] []

Name (First, Last) _____ Date of Birth (MM/DD/YYYY) [] [] / [] [] / [] [] [] []

Shipping Address (Please do not use P.O. Box) _____ Daytime Phone () ()

City _____ State _____ ZIP Code _____ Evening Phone () ()

E-mail Address _____ Dr. Name _____ Dr. Phone (Required) () ()

ALLERGIES: No Known 32-Codeine 70-Penicillin
 87-Sulfa 93-Tetracycline Other (list): _____

HEALTH CONDITIONS: No Known 200-Diabetes 300-Hypertension
 400-Heart Disease 500-Glaucoma 600-Stomach disorders
 700-Thyroid disease 800-Arthritis Other (list): _____

PAYMENT - CHECK OR CREDIT CARD (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS)

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 allowable by law. If you do not want a generic equivalent, please call our Customer Care Center to advise.	Number enclosed	Cost (ea.)	Subtotal
		\$	\$
		\$	\$
	TOTAL AMOUNT ENCLOSED		\$
Please contact Prescription Blue member services with benefits questions at 1-800-565-1770.			

Credit Card Number []

Credit Card Expiration (MM/YY) [] [] / [] [] Signature (for credit card) _____

Mail to : Walgreens Mail Service P.O. Box 628001, Orlando, FL 32862-8001

