



# Registration and Prescription Order Form



991000TNBCCTNB001

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: TNBCC

UPI#: TNB001

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

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			Payment Options		
Allergies	Health Conditions	Order Preference	<i>Payment is required at time of order. Please do not send cash.</i>		
<input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine derivatives <input type="radio"/> Morphine derivatives <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> None known <input type="radio"/> Other (Use lines below) _____ _____	<input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Glaucoma <input type="radio"/> Heart disease <input type="radio"/> Hypertension <input type="radio"/> Pregnancy <input type="radio"/> Thyroid disease <input type="radio"/> None known <input type="radio"/> Other (Use lines at right) _____ _____	<input type="radio"/> Easy-open caps <input type="radio"/> Large-print vial labels <input type="radio"/> Spanish vial labels _____ _____	We accept American Express®, Discover®, MasterCard® and Visa®. <input type="radio"/> Check made payable to Walgreens Mail Service <input type="radio"/> Charge credit card below for this order only <input type="radio"/> Place credit card below on file for this and all future orders		
			Credit Card Number <input type="text"/> Expiration Date [MM/YY] <input type="text"/> / <input type="text"/>		
			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 _____		



992000TNCCTNB001

**DEPENDENT INFORMATION**

- Male
- Female

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

For separate shipping, please contact the Customer Care Center toll free at 877-380-8077.

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

**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 877-380-8077.

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
  - Next Business Day (\$17.95\*)
  - 2nd Business Day (\$10.95\*)
- NO CHARGE**

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 628001  
Orlando, FL 32862-8001

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