

REGISTRATION & PRESCRIPTION ORDER FORM

Please PRINT clearly using UPPERCASE letters. Use only black ink. Enclose this form with your mail service prescription. A reorder form and envelope will be included with each delivery.



INTERCOM: HUMNA

UPI: HUM002

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

MEMBER ID NUMBER (COPY FROM ID CARD) [Grid]

SUFFIX NUMBER [Grid]

SUFFIX NUMBER

Please complete both pages of this form.

MEMBER ID NUMBER (COPY FROM ID CARD)

#1 MEMBER INFORMATION

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) Male Female

Address (please do not use P.O. Box)

City State ZIP Code

Daytime Phone Evening Phone

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

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

Dr. Name (print) Dr. Phone (very important)

Check if patient needs snap-on caps. Check if patient needs Spanish vial labels.

IMPORTANT

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Healthcare Plus 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 Service number to advise.

PAYMENT (required at time of order):

Table with columns: Number of Rx's enclosed, Cost (ea.), Subtotal. Includes TOTAL AMOUNT ENCLOSED and a note to refer to benefit materials for copayment information.

Checks payable to:

Walgreens Healthcare Plus P.O. Box 628001 Orlando, FL 32862-8001

CUSTOMER SERVICE:

1-800-504-3780

TTY for hearing impaired:

1-800-925-0178

REFILLS BY PHONE:

1-800-749-0009

(en español: 1-800-758-0002)

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; no cash, please) [Grid]

CREDIT CARD EXPIRATION [Grid]

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; no cash, please)

CREDIT CARD EXPIRATION

Thank you for your order. Please allow two weeks for delivery from the date you mail your order



<input type="text"/> <input type="text"/> DEPENDENT INFORMATION Print patient ID No. in boxes at left (located on ID card, if applic.)		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Female		
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
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Dr. Name	Dr. Phone (very important) ()	
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City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
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