Medicare Part D

1730MCPNMPDCIT001

Mail Service Registration & Prescription Order Form

Intercom: MCPNMPD UPI#: CIT001

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 (•).

BENEFICIARY INFORMATION: Not all ID and Group Number boxes may be needed.

Beneficiary ID Number (Located on card)

Suffix (if on card)

Group Number

Rx BIN

Rx PCN

Plan Name (Required)

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

Text Message* ○ Yes ○ No

Last Name

First Name

Cell Phone - -

Permanent Address Line 1

Daytime Phone - -

Permanent Address Line 2

Evening Phone - -

City

State

ZIP

Government ID†

○ Male ○ Female

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

Prescriber Last Name

Prescriber First Initial

Prescriber Phone - -

Prescriber Fax - -

**Standard text message and data rates may apply.*

†Most states require ID (driver's license, state ID number, social security number, military ID or passport ID) for controlled Rx substances by law.

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For separate shipping, please contact the
Customer Care Center toll free at 866-817-1632.
TTY 866-573-1833.

BENEFICIARY

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 line below)*

Order Preference

- ○ Large-print vial labels
- ○ Spanish vial labels

Payment Options: Payment is required at time of order. Please do not send cash.

○ Check made payable to Walgreens

○ Charge credit card below for this order only

○ Place credit card on file for this & all future order(s)

We accept American Express®, Discover®, MasterCard® and Visa®.

Credit Card Number

Expiration Date [MM/YY] /

I authorize Walgreens 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 __________

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).

It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens 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 866-817-1632, TTY 866-573-1833.

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

Total included for copay(s).. $.

○ Standard Shipping.. **NO CHARGE**

○ Next Business Day ($19.95†) $.

○ 2nd Business Day ($10.95†) $.

○ Saturday Overnight ($27.95†) $.

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
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.*

Brand names are the property of their respective owners.
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