



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			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 <input type="radio"/> Automatic refill* <i>*Fill in this circle if you would like us to automatically refill your prescriptions in the future.</i>	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 _____		



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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	Health Conditions	Order Preference
<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 below)	<input type="radio"/> Easy-open caps <input type="radio"/> Large-print vial labels <input type="radio"/> Spanish vial labels <input type="radio"/> Automatic refill* <p><i>*Fill in this circle if you would like us to automatically refill your prescriptions in the future.</i></p>

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) \$ []

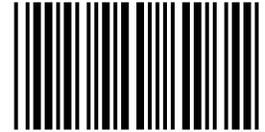
- Standard Shipping
 - Next Business Day (\$17.95*)
 - 2nd Business Day (\$10.95*)
- NO CHARGE**
- \$ []
- \$ []

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 29061
Phoenix, AZ 85038-9061

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



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						<input type="checkbox"/>
	Medication	Strength	Directions	Qty.	# of Refills	DAW
Rx 2						<input type="checkbox"/>

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

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

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