



12100000WHPWHP329



DEPENDENT INFO.		<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="text"/> <input type="text"/> Suffix extension if on ID cards	<input type="checkbox"/> Patient needs snap-on caps	<input type="checkbox"/> Patient needs Spanish vial labels
Name (First, Last)			Date of Birth (MM/DD/YYYY)			
Shipping Address (if different than member)				Daytime Phone ()		
City		State		ZIP Code		Evening Phone ()
E-mail Address			Dr. Name		Dr. Phone (Required) ()	
ALLERGIES:		<input type="checkbox"/> No known		<input type="checkbox"/> 32-Codeine		<input type="checkbox"/> 70-Penicillin
<input type="checkbox"/> 87-Sulfa		<input type="checkbox"/> 93-Tetracycline		<input type="checkbox"/> Other (list):		
HEALTH CONDITIONS:		<input type="checkbox"/> No known		<input type="checkbox"/> 200-Diabetes		<input type="checkbox"/> 300-Hypertension
<input type="checkbox"/> 400-Heart disease		<input type="checkbox"/> 500-Glaucoma		<input type="checkbox"/> 600-Stomach disorders		
<input type="checkbox"/> 700-Thyroid disease		<input type="checkbox"/> 800-Arthritis		<input type="checkbox"/> Other (list):		
DEPENDENT INFO.		<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="text"/> <input type="text"/> Suffix extension if on ID cards	<input type="checkbox"/> Patient needs snap-on caps	<input type="checkbox"/> Patient needs Spanish vial labels
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<input type="checkbox"/> 700-Thyroid disease		<input type="checkbox"/> 800-Arthritis		<input type="checkbox"/> Other (list):		

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Mail Service Pharmacy
New Prescription Order Form

**Customer Care Center:**

1-888-265-1807

(TTY: 1-800-925-0178)

Monday-Friday, 8 a.m. – 8 p.m. (Eastern)

Saturday, 8 a.m. – Noon (Eastern)

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.

Thank you for your order.