



REGISTRATION & PRESCRIPTION ORDER FORM

MEMBER INFORMATION (REQUIRED)

Primary Cardholder Name: _____
First Middle Initial Last

Address: _____
Street (do not use P.O. Box) Suite or Apt # City State Zip

() Daytime Phone

() Evening Phone

Date of Birth: / /
MM DD YYYY

Female: Male: Email Address: _____
Optional

Doctor's Name: _____
First Last

Dr.'s Phone: _____

Patient needs snap-on caps
 Patient needs Spanish vial labels

Allergies:
 32-Codeine 70-Penicillin 87-Sulfa 93-Tetracycline No known allergies
 Other (list): _____

Health Conditions:
 200-Diabetes 300-Hypertension 400-Heart Disease 500-Glaucoma
 600-Stomach Disorders 700-Thyroid Disease 800-Arthritis No known health conditions
 Other (list): _____

EMPLOYER AND PRESCRIPTION COVERAGE INFORMATION

Prescription Benefit Provider/
Pharmacy Drug Insurance: _____

Your Employer Name: _____ Active Retiree

Member ID Number (from ID Card):

Group Number:

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.
Please allow two weeks for delivery.

Please complete both pages ➡

