

Walgreens Mail Service

Registration and Prescription Order Form

To quickly register, visit www.walgreensmail.com.



Please print clearly using only **BLACK INK** and **UPPERCASE** letters.

Your Employer Name: _____

Fill in the applicable circles completely (●). Not all Group and ID number boxes may be needed.

Member Information

- Male
 Female

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

Prescription Benefit Provider/Pharmacy Drug Insurance:

ID Number (located on card)

Suffix (if on card)

Group Number

E-mail Address (to receive information regarding the processing of your order)

Daytime Phone

 - -

Last Name

First Name

Evening Phone

 - -

Permanent Address 1

Permanent Address 2

City

State

ZIP Code

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

 - -

Prescriber Fax

 - -

Dependent Information

- Male
 Female

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

Dependent Last Name

Dependent First Name

Suffix (if on card)

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

 - -

Prescriber Fax

 - -

E-mail Address (to receive information regarding the processing of your order)

Please Complete

Member
Dependent

Allergies

- Aspirin
 Cephalosporin
 Codeine derivatives
 Morphine derivatives
 Penicillin
 Sulfa drugs
 None known
 Other (Use lines below.)

Member
Dependent

Health Conditions

- Arthritis
 Asthma
 Diabetes
 Glaucoma
 Heart disease
 Hypertension
 Pregnancy
 Thyroid disease
 None known
 Other (Use lines at left.)

Order Preference

- Easy-open caps
 Spanish vial labels
 Large-print vial labels
 Auto Refill*

*only applies if mailing in enrollment form with a prescription enclosed

