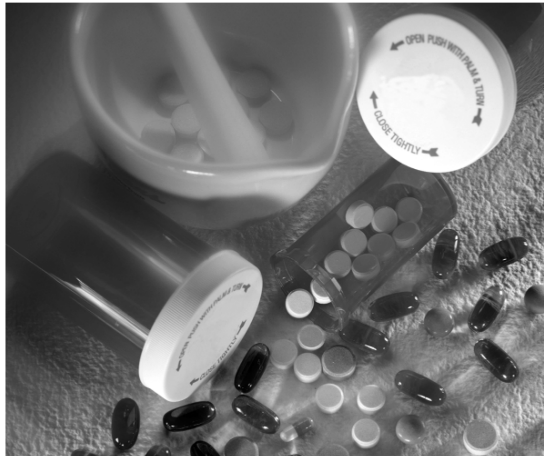
Mail Service Pharmacy

Prescription Order Form



Walgreens Mail Service

P-5336

Mail Service Pharmacy Tips

- Complete registration form.
- New prescriptions must be mailed to the mail service pharmacy or faxed from your doctor's office on the Walgreens Mail Service doctor fax form.
- For long-term medications you need right away: ask your doctor for two prescriptions–one for a small supply to fill at a participating retail pharmacy and one for a long-term supply to fill through the mail.
- If two or more prescriptions are sent in for multiple family members, the prescriptions will be shipped, as a single order, to an adult family member at the address given on the order form. If you prefer different shipping arrangements for privacy or other reasons, please contact our Customer Care Center.
- Most orders are shipped by U.S. Postal Service. Controlled substances may require an adult signature upon receipt. Packaging does not show any indication that medications are enclosed.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted.
- Allow 2 weeks for delivery.
- To save time, please ask your doctor for a new written prescription. Upon request, Walgreens Mail Service will attempt to transfer prescriptions with refills remaining. Please call our Customer Care Center.

Customer Care Center:
1-866-611-5961 (TTY: 1-800-573-1833)
Monday–Friday 7:00 a.m. - 9:00 p.m. (Central)
Saturday–Sunday 7:00 a.m. - 4:00 p.m. (Central)

Refills by Phone:
1-800-RX-REFILL (1-800-797-3345)
(en español: 1-800-778-5427)

Internet:
www.wellmark.com

This brochure only highlights your mail service pharmacy benefit. In case of any discrepancy between this brochure and the legal documents describing the plan, the legal documents govern.

I/06-06

Walgreens Mail Service

Registration & Prescription Order Form

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Please **PRINT** clearly using **UPPERCASE** letters. Use only black ink. Enclose this form with your mail service prescription. A reorder form and envelope will be included with each delivery.

Wellmark Blue Cross and Blue Shield of Iowa

GROUP NO.: **WELLRX** INTERCOM: **WELLM** UPI: **WLM001**

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.

☐☐☐☐☐☐☐☐☐☐☐☐

MEMBER ID NUMBER (VERY IMPORTANT - LOCATED ON THE FRONT OF ID CARD)

Please complete both pages of this form.

#1 Member Information

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ ☐ Male ☐ Female

Address (Please no PO Box)

City	State	ZIP Code

Daytime Phone	Evening Phone
( )	( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ No Known
☐ 200-Diabetes ☐ 600-Stomach Disorders
☐ 300-Hypertension ☐ 700-Thyroid Disease
☐ 400-Heart Disease ☐ 800-Arthritis
☐ 500-Glaucoma ☐ Other (list):

Dr. Name (print)	Dr. Phone (very important)
	( )

☐ Check if patient needs snap-on caps.
☐ Check if patient needs Spanish vial labels.

Important

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Mail Service will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center to advise.

PAYMENT (required at time of order):

No. of Rx's enclosed	Total
	$*

*Please call the number on the front of your ID card for copayment information.

Checks payable to:
Walgreens Mail Service
P.O. Box 5957
Portland, OR 97228-5957

CUSTOMER CARE CENTER:
1-866-611-5961
(☎ TTY for hearing impaired: 1-800-573-1833)

REFILLS BY PHONE:
1-800-RX-REFILL (797-3345)
(en español: 1-800-778-5427)

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; **no cash, please**)

CREDIT CARD EXPIRATION

Thank you for your order. Please allow two weeks for delivery from the date you mail your order.

I/06-06

Dependent Information

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female
__ __ / __ __ / __ __ __ __

Address (please do not use P.O. Box)

City	State	ZIP Code

Daytime Phone	Evening Phone
( )	( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ No Known
☐ 200-Diabetes ☐ 600-Stomach Disorders
☐ 300-Hypertension ☐ 700-Thyroid Disease
☐ 400-Heart Disease ☐ 800-Arthritis
☐ 500-Glaucoma ☐ Other (list):

Dr. Name	Dr. Phone (very important)
	( )

☐ Check if patient needs snap-on caps.
☐ Check if patient needs Spanish vial labels.

Dependent Information

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female
__ __ / __ __ / __ __ __ __

Address (please do not use P.O. Box)

City	State	ZIP Code

Daytime Phone	Evening Phone
( )	( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
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☐ 500-Glaucoma ☐ Other (list):

Dr. Name	Dr. Phone (very important)
	( )

☐ Check if patient needs snap-on caps.
☐ Check if patient needs Spanish vial labels.

Please complete both pages of this form.

Rx FOR: ______ DATE: ______

ADDRESS: ______ TEL: ______

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Mail Service

Dr: ______ DISPENSE AS WRITTEN

Dr: ______ SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): ______

REFILL ______ TIMES ADDRESS ______

DEA # ______ TELEPHONE # ______

Rx FOR: ______ DATE: ______

ADDRESS: ______ TEL: ______

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Mail Service

Dr: ______ DISPENSE AS WRITTEN

Dr: ______ SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): ______

REFILL ______ TIMES ADDRESS ______

DEA # ______ TELEPHONE # ______

I/06-06

FAX ORDER FORM

Wellmark Blue Cross and Blue Shield

INTERCOM: WELLM **UPI NO.: WLM 001**

1 0 9

PHYSICIAN: Please fax fully completed form to Walgreens Mail Service: **1-866-212-5759.**
TO THE PATIENT: Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Walgreens Mail Service, P.O. Box 5957, Portland, OR 97228-5957
Customer Care Center: 1-866-611-5961 (TTY for hearing impaired: 1-800-573-1833)

If you are unable to make an appointment with your doctor, follow these steps to obtain your prescription:

- Fully complete the sections below using **black ink** only.
  A credit card number is required at the time the form is submitted.
- Have your doctor supply the prescription information requested using prescriber's form.
- Have your doctor fax the form to the number above.
  IMPORTANT: To be valid, the prescription must be faxed from your doctor's office.
- Please allow 2 weeks for delivery from the date your physician faxes your prescription in.

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.

MEMBER INFORMATION

Member ID Number (located on ID card)

Group Number

W	E	L	L	R	X

Date of Birth / /

Name (First, Last)

E-mail Address

Address (please do not use P.O. box)

Daytime Phone ( )

City

State

Zip Code

Evening Phone ( )

PATIENT INFORMATION

Patient Name (First, Last if different from above)

☐ Male
☐ Female

Patient Date of Birth (Mo/Day/Yr) / /

Patient E-mail Address

PATIENT ALLERGIES:

☐ No Known ☐ 32-Codeine
☐ 70-Penicillin ☐ 87-Sulfa
☐ 93-Tetracycline ☐ Other (list):

PATIENT HEALTH CONDITIONS:

☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension
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☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ Other (list):

Dr.'s Name

Dr.'s Phone ( )

PAYMENT INFORMATION

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CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express)

CREDIT CARD EXP. ___ / ___