

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 # _____

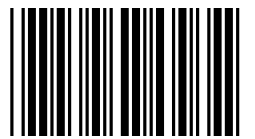
Rx FOR: _____ DATE: _____
 ADDRESS: _____ TEL: _____

**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 # _____

FAX ORDER FORM



(print your company name)

INTERCOM: _____ UPI NO.: _____

PHYSICIAN: Please fax fully completed form to Walgreens Mail Service: **1-800-332-9581**.
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 29061, Phoenix, AZ 85038-9061

Customer Care Center: 1-800-345-1985 (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.

CARDHOLDER INFORMATION

ID Number (located on ID card)										Suffix if on card		
Group Number										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)			<input type="checkbox"/> Male	Patient Date of Birth (Mo/Day/Yr)	
			<input type="checkbox"/> Female	/ /	
Patient E-mail Address					
PATIENT ALLERGIES:		PATIENT HEALTH CONDITIONS:			
<input type="checkbox"/> No Known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> No Known	<input type="checkbox"/> 200-Diabetes	<input type="checkbox"/> 300-Hypertension	
<input type="checkbox"/> 70-Penicillin	<input type="checkbox"/> 87-Sulfa	<input type="checkbox"/> 400-Heart Disease	<input type="checkbox"/> 500-Glaucoma	<input type="checkbox"/> 600-Stomach Disorders	
<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):	<input type="checkbox"/> 700-Thyroid Disease	<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):	
Dr.'s Name			Dr.'s Phone ()		

PAYMENT INFORMATION

PLEASE NOTE: 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 number to advise.

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

CREDIT CARD NUMBER										CREDIT CARD EXP.	
										/	

WHI/11-04