



An Independent Licensee of the Blue Cross and Blue Shield Association

Mail Service Pharmacy Prescription Order Form



Walgreens
Mail Service

P-5336 8-07

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.
- Your prescription(s) may be filled for up to the plan days supply maximum when allowed by your physician, the law, and in accordance with pharmacy practice. Some medications may only be dispensed for the exact quantity as written by your physician.
- 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.

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.walgreensmail.com/wellmark

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.

Walgreens Mail Service

REGISTRATION & PRESCRIPTION ORDER FORM

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.

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MEMBER ID NUMBER (VERY IMPORTANT)

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SUFFIX NUMBER

Please complete both pages of this form.

#1 MEMBER INFORMATION		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY)		<input type="checkbox"/> Male
<input type="text"/>	/ <input type="text"/>	/ <input type="text"/>
		<input type="checkbox"/> Female
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
HEALTH CONDITIONS: <input type="checkbox"/> No Known <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 500-Glaucoma <input type="checkbox"/> Other (list):		
Dr. Name (print)	Dr. Phone (very important)	
	()	
<input type="checkbox"/> Check if patient needs snap-on caps. <input type="checkbox"/> 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):

Rx Type	No.	Cost (each)	Subtotal
Generic		*	\$
Brand		*	\$
			\$
TOTAL AMOUNT ENCLOSED			\$
*Please call the number on the front of your ID Card for copayment information.			

Checks payable to:
Walgreens Mail Service
 P.O. Box 29061
 Phoenix, AZ 85038-9061
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)

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

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CREDIT CARD EXPIRATION

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



<input type="text"/> <input type="text"/> DEPENDENT INFORMATION Print patient ID No. in boxes at left (located on ID card, if applic.)		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY)		<input type="checkbox"/> Male
<input type="text"/> <input type="text"/>	/ <input type="text"/> <input type="text"/>	/ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		<input type="checkbox"/> Female
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
HEALTH CONDITIONS: <input type="checkbox"/> No Known <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 500-Glaucoma <input type="checkbox"/> Other (list):		
Dr. Name	Dr. Phone (very important) ()	
<input type="checkbox"/> Check if patient needs snap-on caps. <input type="checkbox"/> Check if patient needs Spanish vial labels.		

<input type="text"/> <input type="text"/> DEPENDENT INFORMATION Print patient ID No. in boxes at left (located on ID card, if applic.)		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY)		<input type="checkbox"/> Male
<input type="text"/> <input type="text"/>	/ <input type="text"/> <input type="text"/>	/ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		<input type="checkbox"/> Female
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
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