

Prescription Drug Plan: _____

Use this form to register/submit your first prescription order. **You can also register at alliancerxwp.com/home-delivery. DO NOT** staple, tape or paper clip anything to this form.

Please print clearly using only **BLACK INK** and **UPPERCASE** letters. Fill in the applicable circles completely (•). **Not all ID and Group Number boxes may be needed.**

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

Member ID Number (Located on card) Email Address (To receive information regarding the processing of your order)

Suffix (If on card) BIN (Located on card) PCN (Located on card) Group (Rx Group) Number Located on card

Last Name First Name Cell Phone - -

Permanent Address Line 1 Work Phone - -

Permanent Address Line 2 Home Phone - -

City State ZIP Code Government ID (Most states require ID for controlled Rx substances by law)†

Prescriber Last Name Prescriber First Initial Prescriber Phone - - Prescriber Fax - -

Allergies	Health Conditions	Order Preference	Payment Options
<input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine derivatives <input type="radio"/> Morphine derivatives <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> None known <input type="radio"/> Other (Use lines below) _____ _____	<input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Glaucoma <input type="radio"/> Heart disease <input type="radio"/> Hypertension <input type="radio"/> Pregnancy <input type="radio"/> Thyroid disease <input type="radio"/> None known <input type="radio"/> Other (Use lines at right) _____ _____	<input type="radio"/> Large-print labels <input type="radio"/> Spanish vial labels <input type="radio"/> Automatic refill ‡ ‡Fill in this circle if you would like us to automatically refill your prescriptions in the future.	

†Driver's license, state ID number, social security number, military ID or passport ID.



DEPENDENT INFORMATION

- Male
- Female

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

For separate shipping, please contact the Customer Care Center toll free at 800-345-1985.

Dependent Last Name

Dependent First Name

Suffix (if on card)

Email address (To receive information regarding the processing of your order)

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

DEPENDENT

Allergies

Health Conditions

Order Preference

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

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

- Large-print vial labels
 - Spanish vial labels
 - Automatic refill ~~†~~
- ~~†~~ Fill in this circle if you would like us to automatically refill your prescriptions in the future.

ORDER INFORMATION — If including a prescription order, please complete this section.

Please allow 10 business days from the time that you place your order to receive your prescription(s). A refill order form and return envelope will be included with your shipment.

Generic equivalents are usually less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. I do not accept a generic equivalent. By submitting this form, you have authorized release of all information to AllianceRx Walgreens Prime (and other necessary parties) as required to process your order under your benefit plan.

Total number of prescriptions in this order

- Standard shipping **NO CHARGE**
- Next business day (\$19.95†) \$
- Second business day (\$12.95†) \$

Total Payment Enclosed.....\$

†Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.

Please print your name and date of birth on all prescriptions; enclose them along with this completed form and mail to:

AllianceRx Walgreens Prime
P.O. Box 29061
Phoenix, AZ 85038-9061