

# Walgreens Mail Service Registration & Prescription Order Form

## Harvard Pilgrim Health Care



99100001HARVHPC001

Use this form to register/submit your first prescription order. You can also register at [WalgreensHealth.com](http://WalgreensHealth.com). DO NOT staple, tape or paperclip 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.**

### MEMBER INFORMATION

Male  
 Female

Date of Birth [MM/DD/YYYY]

Intercom: HARV

UPI#: HPC001

Member ID Number (located on card)

Suffix (if on card)

Group Number

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

Last Name

First Name

Cell Phone

Text Msg\*  Yes  No

Permanent Address Line 1

Daytime Phone

Permanent Address Line 2

Evening 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

### MEMBER

#### Allergies

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

#### Health Conditions

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

#### Order Preference

- 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.

#### Payment Options

- Check made payable to Walgreens
- Charge credit card below for this order only
- Place credit card below on file for this and all future orders

Payment is required at time of order. Please do not send cash. We accept American Express®, Discover®, MasterCard® and Visa®.

Credit Card Number  
Expiration Date [MM/YY]

I authorize Walgreens to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Standard text message and data rates may apply.  
†Driver's license, state ID number, social security number, military ID or passport ID.



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For separate shipping, please contact the  
Customer Care Center toll free at 877-347-3216.

**DEPENDENT INFORMATION**

Male  
 Female

Date of Birth (MM/DD/YYYY)

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
<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"/> Sulfra 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 below)	<input type="radio"/> Large-print vial labels <input type="radio"/> Automatic refill* <input type="radio"/> Spanish vial labels
<p>*Fill in this circle if you would like us to automatically refill your prescriptions in the future.</p>		

**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.

It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens will dispense an FDA-approved generic equivalent if available, permitted by your prescriber and allowed by state law. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at 877-347-3216.

By submitting this form, you have authorized release of all information to Walgreens (and other necessary parties) as required to process your order under your benefit plan.

Total number of prescriptions in this order.....

Total included for copay(s)..... \$

Standard Shipping  
 Next Business Day (\$19.95 f)  
 2nd Business Day (\$10.95 f)

Total Payment Due..... \$

NO CHARGE

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

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

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