



Registration and Prescription Order Form Medica



991000PHPMNMDP008

Use this form to register/submit your first prescription order. You can also register at **WalgreensMail.com/easy**. 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: PHPMN

UPI#: MDP008

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 1

Daytime Phone

 - -

Permanent Address 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
- Sulfa 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

- Easy-open caps
- 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

Payment is required at time of order. Please do not send cash.

We accept American Express®, Discover®, MasterCard® and Visa®.

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

Credit Card Number

Expiration Date [MM/YY]

 /

I authorize Walgreens Mail Service 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 _____

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

