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DEPENDENT INFORMATION (Print additional pages if you have coverage for multiple dependents)

Be sure to complete Member Information section

Dependent Name: _____
First Middle Initial Last

Address: _____
Street (do not use P.O. Box) Suite or Apt # City State Zip

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Daytime Phone Evening Phone

Date of Birth: / / Relationship to Cardholder: _____
MM DD YYYY

Female: Male: Email Address: _____
Optional

Doctor's Name: _____ Dr's Phone: _____
First Last

Patient needs snap-on caps
 Patient needs Spanish vial labels
Allergies:
 32-Codeine 70-Penicillin 87-Sulfa 93-Tetracycline No known allergies
 Other (list): _____

Health Conditions:
 200-Diabetes 300-Hypertension 400-Heart Disease 500-Glaucoma
 600-Stomach Disorders 700-Thyroid Disease 800-Arthritis No known health conditions
 Other (list): _____

CREDIT CARD INFORMATION

Credit Card Number: _____
(Visa, MasterCard, Discover)

Credit Card Number: _____
(American Express)

Name as it appears on card: _____
First Middle Initial Last

Expiration Date: / / Signature: _____
MM DD YYYY

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 at 1-800-999-2655 to advise.

Simply mail your original prescription and this form along with your credit card information or check made payable to:

Walgreens Mail Service, P.O. Box 628001, Orlando, FL 32862-8001
Customer Care Center: 1-800-999-2655 (TTY for hearing impaired: 1-800-925-0178)
Refills by Phone: 1-800-749-0009 (en español: 1-800-758-0002)
Internet: www.walgreensmail.com