

Mail Service Pharmacy Tips

- Complete attached registration form. You may also register yourself (and dependents, if applicable) at www.mywhi.com.
- New prescriptions must be mailed to the mail service pharmacy.
- 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.
- Allow 2 weeks for delivery.
- Emergency prescriptions can be shipped overnight. Please call our Customer Care Center.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted.
- Refills cannot be transferred from other pharmacies. Request a new prescription from your doctor.

Customer Care Center:

1-888-265-1807 (TTY: 1-800-925-0178)

Monday–Friday, 8:00 a.m. – 8:00 p.m. (Eastern)

Saturday, 8:00 a.m. – Noon (Eastern)

Refills by Phone:

1-800-749-0009

(en español: 1-800-758-0002)

Internet:

www.mywhi.com

Walgreens Mail Service



1200000WHIWHP562

RxGrp514320

Int +WHI

UPI WHP562

REGISTRATION & PRESCRIPTION ORDER FORM

Use black ink only. Enclose form with prescription(s) and payment.

MEMBER INFO.		Suffix extension <input type="checkbox"/> Patient needs snap-on caps		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> if on ID card	<input type="checkbox"/> Patient needs Spanish vial labels		
ID Number (Important - copy from ID card) <input type="text"/>				
Name (First, Last) <input type="text"/>		Date of Birth (MM/DD/YYYY) <input type="text"/>		
Shipping Address (Please do not use P.O. Box) <input type="text"/>			Daytime Phone <input type="text"/>	
City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/>	Evening Phone <input type="text"/>	
E-mail Address <input type="text"/>		Dr. Name <input type="text"/>	Dr. Phone (Required) <input type="text"/>	
ALLERGIES:		<input type="checkbox"/> 70-Penicillin		
<input type="checkbox"/> 87-Sulfa	<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine		
	<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):		
HEALTH CONDITIONS:		<input type="checkbox"/> 300-Hypertension		
<input type="checkbox"/> 400-Heart disease	<input type="checkbox"/> No known	<input type="checkbox"/> 200-Diabetes		
<input type="checkbox"/> 700-Thyroid disease	<input type="checkbox"/> 500-Glaucoma	<input type="checkbox"/> 600-Stomach disorders		
	<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):		
PAYMENT – CHECK OR CREDIT CARD (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS)				
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 number to advise.	Rx Type	No.	Cost (ea.)	Subtotal
	Generic			\$
	Brand			\$
				\$
				\$
TOTAL AMOUNT ENCLOSED			\$	
Credit Card Number <input type="text"/>				
Credit Card Expiration (MM/YY) <input type="text"/>		Signature (for credit card) <input type="text"/>		
Mail to: Walgreens Mail Service P.O. Box 29061, Phoenix, AZ 85038-9061				

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Turn page and complete dependent info. on the other side of this form.



12100000WHIWHP562

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DEPENDENT INFO.		<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="text"/> <input type="text"/> Suffix extension if on ID cards	<input type="checkbox"/> Patient needs snap-on caps	<input type="checkbox"/> Patient needs Spanish vial labels
Name (First, Last)			Date of Birth (MM/DD/YYYY)			
Shipping Address (if different than member)			Daytime Phone ()			
City	State	ZIP Code	Evening Phone ()			
E-mail Address		Dr. Name	Dr. Phone (Required) ()			
ALLERGIES:	<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> 70-Penicillin			
<input type="checkbox"/> 87-Sulfa	<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):				
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Name (First, Last)			Date of Birth (MM/DD/YYYY)			
Shipping Address (if different than member)			Daytime Phone ()			
City	State	ZIP Code	Evening Phone ()			
E-mail Address		Dr. Name	Dr. Phone (Required) ()			
ALLERGIES:	<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> 70-Penicillin			
<input type="checkbox"/> 87-Sulfa	<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):				
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Mail Service Pharmacy
New Prescription Order Form

**Customer Care Center:**

1-888-265-1807

(TTY: 1-800-925-0178)

Monday-Friday, 8 a.m. – 8 p.m. (Eastern)

Saturday, 8 a.m. – Noon (Eastern)

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.

Thank you for your order.