Your pharmacy benefit includes mail service, offering you convenient delivery of your maintenance medications from Walgreens to the location of your choice. Maintenance medications are used to treat chronic (long-term) conditions. You may receive up to a three-month supply or the maximum allowed by your plan.

Getting Started
It's easy to register and order your first prescription:

**Online**: Register at WalgreensHealth.com. From the registration confirmation page, follow the instructions to submit your new prescription.

**By mail**: Complete the registration form included with your enrollment packet. Mail the form along with your original prescription.

**By phone**: Call our Customer Care Center and have your insurance information handy.

**Additional ordering options after registration**: Ask your prescriber to fax or e-prescribe your new prescription.*
- **Fax**: Use the enclosed fax form or log in to your online account to print a prescriber fax form. Give the form to your prescriber to complete and fax to the number listed on the form.
- **E-prescribe**: If your prescriber has the technology to submit prescriptions electronically, request that he or she do so.

**If you need your medication right away**:
Request two prescriptions from your prescriber: one for an initial short-term supply (e.g., 30-day supply or the amount allowed by your plan) that your local pharmacy can fill immediately and one for a 90-day supply with three refills (or the maximum amount allowed by your plan) to mail to Walgreens.

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*By law, prescription fax forms and e-prescriptions are valid only if sent from a prescriber's office.*

**Free standard shipping**: Please allow 10 business days from the time you place your order until you receive it at the address you specified.

**Flexible Payment Options**
Payment in full—by credit card or check—is required with every prescription order. We accept all major credit cards. For your convenience, we can keep your credit card on file for future orders by adding it to your secure online account. Simply complete the fields on your registration form or call our Customer Care Center.
Mail prescriptions to:
Walgreens
P.O. Box 29061
Phoenix, AZ 85038-9061

Walgreens Customer Care Center
800-345-1985
Monday through Friday,
8 a.m. to 10 p.m. EST
Saturday and Sunday,
8 a.m. to 5 p.m. EST
En español: 800-778-5427
TTY: 800-573-1833

**Savings With Generics**
Generic medications offer the same benefits as their brand-name counterparts and usually cost significantly less. We review every prescription order to see if there is a less-expensive generic medication available. Unless otherwise noted by your prescriber or state law, we will dispense an FDA-approved generic equivalent, if available. If you do not want a generic, please contact our Customer Care Center.

**Privacy and Security**
The information you provide us is kept confidential in accordance with HIPAA and other applicable state privacy laws. In addition, we use technology that is designed for use with secure Web servers. This technology ensures that your personal health, prescription and credit card information cannot be accessed when submitted over the Internet.

Welcome to Mail Service Pharmacy
Convenient, reliable delivery for the members of **MEDTRAK**

For more information, visit: WalgreensHealth.com

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W0012-1011
Use this form to register/submit your first prescription order. You can also register at 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: MTRAK

UPI#: MTS001

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

Daytime Phone

Evening Phone

---

**Permanent Address Line 1**

**Permanent Address Line 2**

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**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Health Conditions</th>
<th>Order Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Aspirin</td>
<td>○ Arthritis</td>
<td>○ Large-print vial labels</td>
</tr>
<tr>
<td>○ Cephalosporin</td>
<td>○ Asthma</td>
<td>○ Spanish vial labels</td>
</tr>
<tr>
<td>○ Codeine derivatives</td>
<td>○ Diabetes</td>
<td></td>
</tr>
<tr>
<td>○ Morphine derivatives</td>
<td>○ Glaucoma</td>
<td></td>
</tr>
<tr>
<td>○ Penicillin</td>
<td>○ Heart disease</td>
<td></td>
</tr>
<tr>
<td>○ Sulfas drugs</td>
<td>○ Hypertension</td>
<td></td>
</tr>
<tr>
<td>○ None known</td>
<td>○ Pregnancy</td>
<td></td>
</tr>
<tr>
<td>○ Other (Use lines below)</td>
<td>○ Thyroid disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ None known</td>
<td></td>
</tr>
<tr>
<td></td>
<td>○ Other (Use lines at right)</td>
<td></td>
</tr>
</tbody>
</table>

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**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
- ○ 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 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 ____________

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

Health Conditions
- Arthritis
- Asthma
- Diabetes
- Glaucoma
- None known
- Hypertension
- Pregnancy
- Thyroid disease
- Other

Order Preference
- Large-print vial labels
- Spanish vial labels

DEPARTMENT 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 800-345-1985.

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 copy(s)..............................................................

Standard Shipping
- Next Business Day ($19.95†)
- 2nd Business Day ($10.95†)

Total Payment Due..............................................................

† 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:

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

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### PATIENT SECTION

**Patient:** To have your order processed, you must be registered with and have current credit card and shipping information on file with Walgreens. You can register online at [WalgreensHealth.com](http://WalgreensHealth.com) or by mail using the form included in your enrollment kit.

**IMPORTANT NOTICE:** 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 600-345-1985.

After you are registered, please print your member ID number listed on your ID card, your phone number and address in the space below and give this form to your prescriber to complete and fax to us.

<table>
<thead>
<tr>
<th>Member ID Number (Located on card)</th>
<th>Patient Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>ZIP Code</td>
<td></td>
</tr>
</tbody>
</table>

### PRESCRIBER SECTION

**Prescriber:** Fax this completed form to Walgreens at 800-332-9581. Your signature and date are required. Most prescription drug plans allow up to a 90-day supply with three refills.

**Print and use BLACK INK only. NOT VALID FOR CII PRESCRIPTIONS.**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB [MM/DD/YYYY]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
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<table>
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<th>Medication</th>
<th>Strength</th>
<th>Directions</th>
<th>Qty.</th>
<th># of Refills</th>
<th>DAW</th>
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<tbody>
<tr>
<td>Rx 1</td>
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<tr>
<td>Rx 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date _______ NPI# _______ DEA# _______ Required for Controlled Substances

Prescriber Signature _______ 

Prescriber Name (Please print) _______

Prescriber Address _______ 

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>
| Prescriber Phone _______ | Prescriber Fax _______ | Check box if this is a new fax number

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you under appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT NOTICE: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential. The disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error please notify us immediately.

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