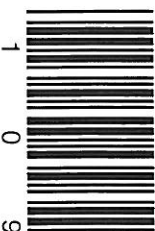


# FAX ORDER FORM

Health Management Administrators

INTERCOM: PCSMO UPI NO.: HMA 001



PHYSICIAN: Please fax fully completed form to Walgreens Mail Service: 1-866-212-5759.  
 TO THE PATIENT: Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Walgreens Mail Service, P.O. Box 5957, Portland, OR 97228-5957  
 Customer Care Center: 1-800-635-3070 (TTY for hearing impaired: 1-800-573-1833)

If you are unable to make an appointment with your doctor, follow these steps to obtain your prescription:

- Fully complete the sections below using **black ink only**.
- A credit card number is required at the time the form is submitted.
- Have your doctor supply the prescription information requested using prescriber's form.
- Have your doctor fax the form to the number above.
- IMPORTANT: To be valid, the prescription must be faxed from your doctor's office.**
- Please allow 2 weeks for delivery from the date your physician faxes your prescription in.

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.

## MEMBER INFORMATION

ID Number (located on ID card)		Suffix if on card	
Group Number		Date of Birth	/ /
Name (First, Last)	E-mail Address		
Address (please do not use P.O. box)			
City	State	Zip Code	Daytime Phone ( ) Evening Phone ( )
<b>PATIENT INFORMATION</b>			
Patient Name (First, Last if different from above)		Male Female	Patient Date of Birth (Mo/Day/Yr) / /
Patient E-mail Address			
<b>PATIENT ALLERGIES:</b>		<b>PATIENT HEALTH CONDITIONS:</b>	
<input type="checkbox"/> No Known	<input type="checkbox"/> 32-Codaine	<input type="checkbox"/> 200-Diabetes	<input type="checkbox"/> 300-Hypertension
<input type="checkbox"/> 70-Penicillin	<input type="checkbox"/> 87-Sulfis	<input type="checkbox"/> 400-Heart Disease	<input type="checkbox"/> 500-Glaucoma
<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):	<input type="checkbox"/> 700-Thyroid Disease	<input type="checkbox"/> 800-Arthritis
Dr.'s Name		Dr.'s Phone ( )	
<b>PAYMENT INFORMATION</b>			

**PLEASE NOTE:** 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 to advise.

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express) CREDIT CARD EXP.

## Facsimile Not valid for CII prescriptions Valid only at Walgreens Mail Service

Rx FOR: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ TEL: \_\_\_\_\_

Dr: \_\_\_\_\_ DISPENSE AS WRITTEN \_\_\_\_\_  
 SUBSTITUTION PERMISSIBLE  
 MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): \_\_\_\_\_  
 REFILL \_\_\_\_\_ TIMES ADDRESS \_\_\_\_\_  
 DEA # \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

Rx FOR: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ TEL: \_\_\_\_\_

## Facsimile Not valid for CII prescriptions Valid only at Walgreens Mail Service

Dr: \_\_\_\_\_ DISPENSE AS WRITTEN \_\_\_\_\_  
 SUBSTITUTION PERMISSIBLE  
 MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): \_\_\_\_\_  
 REFILL \_\_\_\_\_ TIMES ADDRESS \_\_\_\_\_  
 DEA # \_\_\_\_\_ TELEPHONE # \_\_\_\_\_