

## Home Delivery Registration Form

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Prescription Drug Plan: _				991
		r. You can also register at AllianceRxWP.com/l	<b>home-deliverv</b> . <b>DO NOT</b> stap	le, tape or paperclip anything to this form.
	, , ,	RCASE letters. Fill in the applicable circles com	• '	
MEMBER INFORMATION	○ Male ○ Female	Date of Birth [MM/DD/YYYY] /		
Member ID Number (Located	on card)	Email Address (To receive information	n regarding the processing o	f your order)
Suffix (If on card) BIN (Loca	ted on card) PCN (Located on	card)	Group	(Rx Group) Number (Located on card)
Last Name		First Name		Cell Phone Text Msg?* Yes No
Permanent Address (Line 1)				Work Phone
Permanent Address (Line 2)				Home Phone
City		State Zip Code Gov	ernment ID <i>(Most states req</i>	uire ID for controlled Rx substances by law)
Prescriber Last Name		Prescriber First Initial Prescriber F	Phone — — — — — — — — — — — — — — — — — — —	Prescriber Fax
Allergies	MEMBER Health Conditions	Order Preference	Payment Options	
○ Aspirin	Arthritis	O Large-print vial labels		** We accept checks and credit cards.
O Cepalosporin	O Asthma	O Spanish vial labels	Checks should be made payable to AllianceRx Walgreens Pharmacy	
<ul><li>Codeine derivatives</li><li>Morphine derivatives</li></ul>	O Diabetes O Glaucoma	Automatic refill <sup>‡</sup> ‡Fill in this circle if you would like us to automatically refill	We accept Visa, MasterCard, Discover and American Express.	
O Penicillin	O Heart disease	your prescriptions in the future.  FOR CALIFORNIA PATIENTS: Before AllianceRx Walgreens	Please visit AllianceRxWP.com/home-delivery to pay by credit card.  You will need to create an account: Go to Settings & Payment then Payment Methods to enter a credit card number.	
○ Sulfa drugs ○ None known	<ul><li>○ Hypertension</li><li>○ Pregnancy</li></ul>	Pharmacy can turn on Auto Refill for California patients, patients must agree in writing or by electronic notice.  Enrollment will remain active for one year from the date		
Other (use lines below)	<ul><li>○ Thyroid disease</li><li>○ None known</li><li>○ Other (use lines below)</li></ul>	you selected.	You can also call our Custo 800-345-1985, TTY 800-925	mer Care Center for assistance at: 5-0178
	Other (use lines below)			

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DEPENDANT INFORMAT  Dependent Last Name	O Male Date of Female	of Birth [MM/DD/YYYY] Dependent I			For separate shipping, please contact the Customer Care Center for assistance at: 800-345-1985, TTY 800-925-0178
Dependent East Name		Dependent i	iist rame		
Suffix (If on card) Email A	Address (To receive information	n regarding the process	ing of your order)		
Prescriber Last Name		Prescriber F	irst Initial Prescriber Ph	one 	Prescriber Fax
Alle	ergies		<b>Health Conditions</b>		Order Preference
<ul><li>Aspirin</li><li>Cepalosporin</li><li>Codeine derivatives</li><li>Morphine derivatives</li></ul>	<ul><li>○ Penicillin</li><li>○ Sulfa drugs</li><li>○ None known</li><li>○ Other (use lines below)</li></ul>	<ul><li>○ Arthritis</li><li>○ Asthma</li><li>○ Diabetes</li><li>○ Glaucoma</li></ul>	<ul><li>Heart disease</li><li>Hypertension</li><li>Pregnancy</li><li>Thyroid disease</li></ul>	○ None known ○ Other (use lines below)	<ul> <li>Large-print vial labels</li> <li>Spanish vial labels</li> <li>Automatic refill<sup>‡</sup></li> <li>‡Fill in this circle if you would like us to automatically refill your prescriptions in the future.</li> </ul>
Please allow 10 business da Generic equivalents are usually brand and generic price of each By submitting this form, you ha	less expensive than brand name n drug. If allowed by your prescrib ve authorized release of all inforn	e your order to receive y drugs. If we dispense a b er, we will dispense a gen nation to AllianceRx Walg	our prescription(s). A refi rand name drug, you may be eric equivalent unless you ch	responsible for a higher coneck this box. $\Box$ I do not ac	envelope will be included with your shipment. payment and/or the difference between the except a generic equivalent. ed to process your order under your benefit plan.
• •	ns in this order				
Total included for copay(s)	\$				
O Standard Shipping: O Next Business Day (\$19.9 O 2 <sup>nd</sup> Business Day (\$12.95 <sup>†</sup>		NO CHARGE \$		close them along with thi	ate of birth on all prescriptions; s completed form and mail to: greens Pharmacy
Total Payment Due:	\$				ox 29061 Z 85038-9061
†Shipping prices may be subjec	t to change by carrier without not	fication and may vary		i nocilia, A	

Brand names are the property of their respective owners.

depending upon weight and zone.