Rx FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

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

Dr: _____ 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: _____ Dr: _____
DISPENSE AS WRITTEN — SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

I/03-05

# FAX ORDER FORM

## Priority Health

**INTERCOM: PRIOR** **UPI NO.: PRY 001**

1 0 9

**PHYSICIAN:** Please fax fully completed form to Walgreens Mail Service: **1-888-595-1258.**
**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 628001, Orlando, FL 32862-8001**
**Customer Care Center: 1-800-999-2655** (TTY for hearing impaired: 1-800-925-0178)

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.**

### CONTRACT HOLDER INFORMATION

ID Number (located on ID card) | Suffix Number -00

Name (First, Last)

E-mail Address | Date of Birth / /

Address (please do not use P.O. box) | Daytime Phone ( )

City | State | Zip Code | Evening Phone ( )

### PATIENT INFORMATION

Patient Name (First, Last if different from above) | ☐ Male ☐ Female | Patient Date of Birth (Mo/Day/Yr) / /

Patient E-mail Address

**PATIENT ALLERGIES:**
☐ No Known ☐ 32-Codeine
☐ 70-Penicillin ☐ 87-Sulfa
☐ 93-Tetracycline ☐ Other (list):

**PATIENT HEALTH CONDITIONS:**
☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension
☐ 400-Heart Disease ☐ 500-Glaucoma ☐ 600-Stomach Disorders
☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ Other (list):

Dr.'s Name | Dr.'s Phone ( )

### PAYMENT INFORMATION

**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. / 