

Healthcare Plus

REGISTRATION & PRESCRIPTION ORDER FORM

Please **PRINT** clearly using **UPPERCASE** letters. Use only black ink. Enclose this form with your mail service prescription. A reorder form and envelope will be included with each delivery.



BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

INTERCOM: LINCS UPI: BCB038

1215

GROUP NUMBER

MEMBER ID NUMBER (VERY IMPORTANT)

MEMBER ID NUMBER (VERY IMPORTANT)

PLEASE NOTE: By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

Please complete both pages of this form.

#1 MEMBER INFORMATION	
Name (First, Last)	
E-mail Address	
Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male	
<input type="checkbox"/> Female	
Address (please do not use P.O. Box)	
City	State ZIP Code
Daytime Phone () () () () () ()	Evening Phone () () () () () ()
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline	
HEALTH CONDITIONS: <input type="checkbox"/> No Known <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 500-Glaucoma <input type="checkbox"/> Other (list):	
Dr. Name (print)	Dr. Phone (very important) () () () () () ()
<input type="checkbox"/> Check if patient needs snap-on caps. <input type="checkbox"/> Check if patient needs Spanish vial labels.	

IMPORTANT

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Healthcare Plus 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 Service number to advise. If you have any questions regarding your pharmacy benefits, please call the Customer Service number on the back of your ID card.

PAYMENT (required at time of order):

Rx Type	No.	Cost (each)	Subtotal
		\$	\$
		\$	\$
		\$	\$
TOTAL AMOUNT ENCLOSED			\$
Signature (for credit card):			

Checks payable to:
Walgreens Healthcare Plus
 P.O. Box 29061
 Phoenix, AZ 85038-9061

Walgreens Healthcare Plus
Customer Service:
1-800-345-1985
 (TTY for hearing impaired:
 1-800-573-1833)

REFILLS BY PHONE:
1-800-RX-REFILL (797-3345)
 (en español: 1-800-778-5427)

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; no cash, please)

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; no cash, please)

CREDIT CARD EXPIRATION

CREDIT CARD EXPIRATION

Thank you for your order. Please allow two weeks for delivery from the date you mail your order



#2 DEPENDENT INFORMATION		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
HEALTH CONDITIONS: <input type="checkbox"/> No Known <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 500-Glaucoma <input type="checkbox"/> Other (list):		
Dr. Name (print)	Dr. Phone (very important) ()	
<input type="checkbox"/> Check if patient needs snap-on caps. <input type="checkbox"/> Check if patient needs Spanish vial labels.		

#3 DEPENDENT INFORMATION		
Name (First, Last)		
E-mail Address		
Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
Address (please do not use P.O. Box)		
City	State	ZIP Code
Daytime Phone ()	Evening Phone ()	
ALLERGIES: <input type="checkbox"/> 70-Penicillin <input type="checkbox"/> Other (list): <input type="checkbox"/> No Known <input type="checkbox"/> 87-Sulfa <input type="checkbox"/> 32-Codeine <input type="checkbox"/> 93-Tetracycline		
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