

Walgreens Mail Service

BLUE CROSS AND BLUE SHIELD OF ILLINOIS REGISTRATION & PRESCRIPTION ORDER FORM



1 1 3 0 I L B C B C B 0 1 9

INTERCOM: ILBC UPI: BCB019

Please **PRINT** clearly using **UPPERCASE** letters. Use black ink only. Enclose this form with your mail order prescription(s).

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GROUP NUMBER (COPY FROM YOUR ID CARD)

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MEMBER ID NUMBER (VERY IMPORTANT)

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"/> 500-Glaucoma <input type="checkbox"/> No Known <input type="checkbox"/> 600-Stomach Disorders <input type="checkbox"/> 200-Diabetes <input type="checkbox"/> 700-Thyroid Disease <input type="checkbox"/> 300-Hypertension <input type="checkbox"/> 800-Arthritis <input type="checkbox"/> 400-Heart Disease <input type="checkbox"/> Other (list):	
<input type="checkbox"/> Check if prescription(s) enclosed for this patient and print:	
Dr. Name	Dr. Phone (very important) ()
<input type="checkbox"/> Check if this patient needs snap-on caps.	

IMPORTANT

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 subscriber, and allowed by law. **If you do not want a generic equivalent, please call Customer Service at (800) 275-7204 to advise.** By making this call I understand that under my applicable health care benefits plan, I am responsible for any higher payment for each brand drug.

PAYMENT (required at time of order):

No. of Rx's enclosed	Total
	\$*
TOTAL AMOUNT ENCLOSED:	\$
*Your payment may vary based on the following plan designs: brand or generic, formulary or coinsurance.	
Signature (for credit card):	

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

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Checks payable to: **Walgreens Mail Service** PO Box 628001, Orlando, FL 32862-8001

PLEASE NOTE: By submitting this form, you authorized the release of all information to Walgreens Mail Service (and to other necessary parties) as required to process your prescriptions and their refills under your benefit plan. Blue Cross and Blue Shield's use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

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



1 1 4 0 I L B C B C B 0 1 9

<input type="text"/>		Print patient ID No. in boxes at left (located on ID card, if applic.)	
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