

Home Delivery Registration & Prescription Order Form

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Prescription Dru	g Plan:	EHIM

Use this form to register/s	ubmit your first prescription order. Y	ou can also register at www	r.alliancerxwp.com/home-delivery. DO NOT staple, tape or paperclip anything to this form.
Please pri	int clearly using only BLACK INK and I	IPPERCASE letters . Fill in the appl	icable circles completely (●). Not all ID and Group Number boxes may be needed.
MEMBER INFORMATION	○ Male○ Female	Date of Birth [Mi	M/DD/YYYY] / / /
Member ID Number <i>(Located on car</i>	d)	Email Address <i>(To recei</i> v	re information regarding the processing of your order)
Suffix (If on card) BIN (Locate 0 0 5	ed on card) PCN (Located on card)	Group Number (<i>Located on card</i>) 5 0 0 0 2 6 4 0 - 0 1
Last Name Permanent Address Line 1		First Name	Cell Phone Work Phone
Permanent Address Line 2			Home Phone
City		State ZIP Code	Government ID (Most states require ID for controlled Rx substances by law)†
Prescriber Last Name		Prescriber First Initial	Prescriber Phone Prescriber Fax
	MEMBER		Payment Options
Allergies Aspirin Cephalosporin Codeine derivatives Morphine derivatives Penicillin Sulfa drugs None known Other (Use lines below)	Health Conditions Arthritis Asthma Diabetes Glaucoma Heart disease Hypertension Pregnancy Thyroid disease None known	Order Preference	**Please do not send cash** We accept checks and credit cards. Checks should be made payable to AllianceRx Walgreens Prime We accept Visa, MasterCard, Discover and American Express. Please visit www.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.
	Other (Use lines at right)		You can also call our Customer Care Center for assistance at 800-345-1985.

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DEPENDENT INFORM Dependent Last Name	ATION O Male O Female	Date of Birth [MM/DD/	YYYYY] / / / / / / / / / / / / / / / / /			te shipping, please contact the e Center toll free at 800-345-1985.
Suffix (If on card) Email	l address <i>(To receive information</i>	regarding the processing of yo	our order)			
Prescriber Last Name		Prescrib(er First Initial Prescribe	er Phone	Prescriber Fa	1X -
			DEPENDENT			
Alle	ergies		Health Conditions		Orde	er Preference
AspirinCephalosporinCodeine derivativesMorphine derivatives	PenicillinSulfa drugsNone knownOther (Use lines below)	○ Arthritis○ Asthma○ Diabetes○ Glaucoma	○ Heart disease○ Hypertension○ Pregnancy○ Thyroid disease	○ None known ○ Other (Use lines below)	○ Large-print vial lab	els O Spanish vial labels
Please allow 10 business days Generic equivalents are usually each drug. If allowed by your pr	from the time that you place you less expensive than brand name of rescriber, we will dispense a generous authorized release of all inform	ur order to receive your pres drugs. If we dispense a brand ric equivalent unless you chec	cription(s). A refill order for name drug, you may be respor k this box.	sible for a higher copayment a a generic equivalent.	ınd/or the difference betv	veen the brand and generic price of
Total number of prescriptions in Standard Shipping Next Business Day (\$19.95†) 2nd Business Day (\$12.95†) Total Payment Enclosed		NO CHARG	E			29061

[†]Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.