

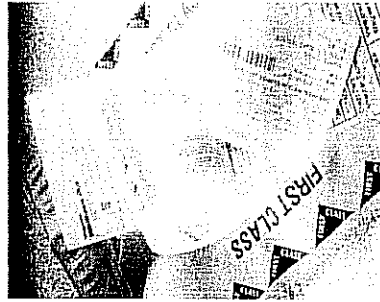
BlueCross[®]
of Idaho



*An Independent Licensee of the
Blue Cross and Blue Shield Association*

Prescription Drug Program

Mail Service
Pharmacy Benefit



provided by

Walgreens
Healthcare Plus

3-311-03-04

MAIL SERVICE PHARMACY TIPS

- Complete attached registration form.
- New prescriptions must be mailed to the mail service pharmacy.
- For long-term medications you need right away: ask your doctor for two prescriptions—one for a small supply to fill at a participating retail pharmacy and one for a long-term supply to fill through the mail.
- To save time, please ask your doctor for a new written prescription. Upon request, Walgreens Healthcare Plus will attempt to transfer prescriptions with refills remaining. Please call Customer Service.
- If two or more prescriptions are sent in for multiple family members, the prescriptions will be shipped, as a single order, to an adult family member at the address given on the order form. If you prefer different shipping arrangements for privacy or other reasons, please contact Customer Service.
- Most orders are shipped by U.S. Postal Service. Controlled substances may require an adult signature upon receipt. Packaging does not show any indication that medications are enclosed.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Healthcare Plus. Credit cards accepted.
- Allow 2 weeks for delivery.

Mail Pharmacy Customer Service:
1-800-635-3070 (TTY: 1-800-573-1833)
Monday–Friday 7:00 a.m. - 5:00 p.m. (Pacific)

Refills by Phone:
1-800-RX-REFILL (1-800-797-3345)
(en español: 1-800-778-5427)

Internet:
www.walgreensmail.com

This brochure only highlights your mail service pharmacy benefit. In case of any discrepancy between this brochure and the legal documents describing the plan, the legal documents govern. F167703-04

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 OF IDAHO

GROUP NO.: 110

INTERCOM: BCID

UPI: BCB036



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.

SUBSCRIBER ID NUMBER (REQUIRED - SEE ID CARD - DO NOT INCLUDE ALPHA PREFIX)

#1 SUBSCRIBER INFORMATION

Name (First, Last)	
E-mail Address	
Date of Birth (MM/DD/YYYY)	Male 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.

PAYMENT (required at time of order):

No. of Rx's enclosed	Total
	\$*

*Please refer to your Benefit booklet for copayment information.

Checks payable to:

Walgreens Healthcare Plus
P.O. Box 188
Beaverton, OR 97075-0188

CUSTOMER SERVICE:

1-800-635-3070

(☎ 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)

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)	Male 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.	

#3 DEPENDENT INFORMATION	
Name (First, Last)	
E-mail Address	
Date of Birth (MM/DD/YYYY)	Male 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.	

Please complete both sides of this form.

detach here

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