FAX ORDER FORM
Physician Order Form

Prescription Drug Program

1 1 7

INTERCOM: CAMA UPI NO.: CRM 001

TO THE PATIENT:

•Please 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 the prescriber's form below.
•Please allow 10 business days for delivery from the date your physician faxes your prescription in.

MEMBER INFORMATION

Group Number	Date of Birth (Mo/Day/Yr) / /	
ID Number (located on ID card)		☐ Male ☐ Female
Name (First, Last)	E-mail Address	
Address (please do not use P.O. box)		Daytime Phone ( )
City	State / ZIP Code	Evening Phone ( )
Dr. Name	Dr. Phone ( )	

☐ Please check if patient needs large print. ☐ Please check if patient needs snap-on caps.

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. /

℞

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 # _____

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 Disorders
☐ 800-Arthritis
☐ Other (list):

PHYSICIAN:

Please fax fully completed form to:
Walgreens Mail Service
1-800-332-9581.