detach here

Please complete both sides of this form. (if applicable)

Walgreens Healthcare Plus

BLUE CROSS AND BLUE SHIELD OF ILLINOIS

REGISTRATION & PRESCRIPTION ORDER FORM

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

(Clearly print your company name below):

_____

INTERCOM: ILBC UPI: BCB019

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

GROUP NUMBER (COPY FROM YOUR ID CARD)

MEMBER ID NUMBER (VERY IMPORTANT)

MEMBER INFORMATION

Name (First, Last)

E-mail address (optional)

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Shipping Address (please do not use P.O. Box)

City	State	ZIP Code

Daytime Phone	Evening Phone
( )	( )

ALLERGIES:
☐ None Known ☐ 70-Penicillin ☐ 87-Sulfa ☐ 32-Codeine ☐ 93-Tetracycline ☐ Other (list):

HEALTH CONDITIONS:
☐ None Known ☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma ☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ Other (list):

Dr. Name (print)	Dr. Phone (very important)
	( )

☐ Check if patient needs snap-on caps.
☐ 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 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):

Checks payable to: **Walgreens Healthcare Plus**
7357 Greenbriar Parkway, Orlando, FL 32819-8917

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

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 applicable health care benefits plan. Blue Cross and Blue Shield of Illinois' 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). The relationship between Blue Cross and Blue Shield of Illinois and Walgreens Healthcare Plus is solely that of independent contractors.

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

EB4049 01/04

F1617/01-04

detach here

Dependent Information

Name (First, Last)

E-mail address (optional)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Shipping Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ None Known
☐ 32-Codeine
☐ 70-Penicillin
☐ 87-Sulfa
☐ 93-Tetracycline
☐ Other (list):

HEALTH CONDITIONS:
☐ None Known
☐ 200-Diabetes
☐ 300-Hypertension
☐ 400-Heart Disease
☐ 500-Glaucoma
☐ 600-Stomach Disorders
☐ 700-Thyroid Disease
☐ 800-Arthritis
☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps
☐ Check if patient needs Spanish vial labels

Dependent Information

Name (First, Last)

E-mail address (optional)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Shipping Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ None Known
☐ 32-Codeine
☐ 70-Penicillin
☐ 87-Sulfa
☐ 93-Tetracycline
☐ Other (list):

HEALTH CONDITIONS:
☐ None Known
☐ 200-Diabetes
☐ 300-Hypertension
☐ 400-Heart Disease
☐ 500-Glaucoma
☐ 600-Stomach Disorders
☐ 700-Thyroid Disease
☐ 800-Arthritis
☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps
☐ Check if patient needs Spanish vial labels

Dependent Information

Name (First, Last)

E-mail address (optional)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Shipping Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ None Known
☐ 32-Codeine
☐ 70-Penicillin
☐ 87-Sulfa
☐ 93-Tetracycline
☐ Other (list):

HEALTH CONDITIONS:
☐ None Known
☐ 200-Diabetes
☐ 300-Hypertension
☐ 400-Heart Disease
☐ 500-Glaucoma
☐ 600-Stomach Disorders
☐ 700-Thyroid Disease
☐ 800-Arthritis
☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps
☐ Check if patient needs Spanish vial labels

Dependent Information

Name (First, Last)

E-mail address (optional)

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

Shipping Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES:
☐ None Known
☐ 32-Codeine
☐ 70-Penicillin
☐ 87-Sulfa
☐ 93-Tetracycline
☐ Other (list):

HEALTH CONDITIONS:
☐ None Known
☐ 200-Diabetes
☐ 300-Hypertension
☐ 400-Heart Disease
☐ 500-Glaucoma
☐ 600-Stomach Disorders
☐ 700-Thyroid Disease
☐ 800-Arthritis
☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps
☐ Check if patient needs Spanish vial labels

detach here

Please complete both sides of this form. (if applicable)

detach here