

Mail Service Pharmacy Tips

- Complete attached registration form. You may also register yourself (and dependents, if applicable) at www.mywhi.com.
- 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.
- 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 our Customer Care Center.
- 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.
- Allow 2 weeks for delivery.
- Emergency prescriptions can be shipped overnight. Please call our Customer Care Center.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted.
- To save time, please ask your doctor for a new written prescription. Upon request, Walgreens Mail Service will attempt to transfer prescriptions with refills remaining. Please call our Customer Care Center.

Customer Care Center:

1-866-855-5446 (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.mywhi.com

cut here ✂

Walgreens Mail Service

City of Salem



12000000WHPWHP803

RxGrp512219

Int +WHP

UPI WHP803

REGISTRATION & PRESCRIPTION ORDER FORM

Use black ink only. Enclose form with prescription(s) and payment.

EMPLOYEE/RETIREE INFO.		<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="text"/>	Suffix extension if on ID card	<input type="checkbox"/> Patient needs snap-on caps	<input type="checkbox"/> Patient needs Spanish vial labels	
ID Number (Important - copy from ID card) <input type="text"/>								
Name (First, Last)						Date of Birth (MM/DD/YYYY)		
Shipping Address (Please do not use P.O. Box)						Daytime Phone		
						()		
City		State		ZIP Code		Evening Phone		
						()		
E-mail Address				Dr. Name		Dr. Phone (Required)		
						()		
ALLERGIES:		<input type="checkbox"/> No known		<input type="checkbox"/> 32-Codeine		<input type="checkbox"/> 70-Penicillin		
<input type="checkbox"/> 87-Sulfa		<input type="checkbox"/> 93-Tetracycline		<input type="checkbox"/> Other (list):				
HEALTH CONDITIONS:		<input type="checkbox"/> No known		<input type="checkbox"/> 200-Diabetes		<input type="checkbox"/> 300-Hypertension		
<input type="checkbox"/> 400-Heart disease		<input type="checkbox"/> 500-Glaucoma		<input type="checkbox"/> 600-Stomach disorders				
<input type="checkbox"/> 700-Thyroid disease		<input type="checkbox"/> 800-Arthritis		<input type="checkbox"/> Other (list):				
PAYMENT – CHECK OR CREDIT CARD (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS)								
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 number to advise.				Rx Type		No.	Cost (ea.)	Subtotal
				Generic			\$*	\$
				Preferred Brand			\$*	\$
				Non-Preferred Brand			\$*	\$
								\$
				TOTAL AMOUNT ENCLOSED				
				\$				
Credit Card Number <input type="text"/>								
Credit Card Expiration (MM/YY)				<input type="text"/>		*Please refer to your Summary Plan Description for copayment amounts.		
Mail to: Walgreens Mail Service P.O. Box 5957, Portland, OR 97228-5957								

cut here ✂

Turn page and complete dependent info. on the other side of this form.



12100000WHPWHP803

cut here ✂



DEPENDENT INFO.		<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Patient needs snap-on caps	<input type="checkbox"/> Patient needs Spanish vial labels
		<input type="checkbox"/> Suffix extension if on ID cards	<input type="checkbox"/>		
Name (First, Last)		Date of Birth (MM/DD/YYYY)			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shipping Address (if different than employee/retiree)			Daytime Phone		
			()		
City	State	ZIP Code	Evening Phone		
			()		
E-mail Address		Dr. Name	Dr. Phone (Required)		
			()		
ALLERGIES:		<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> 70-Penicillin	
<input type="checkbox"/> 87-Sulfa		<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):		
HEALTH CONDITIONS:		<input type="checkbox"/> No known	<input type="checkbox"/> 200-Diabetes	<input type="checkbox"/> 300-Hypertension	
<input type="checkbox"/> 400-Heart disease		<input type="checkbox"/> 500-Glaucoma	<input type="checkbox"/> 600-Stomach disorders		
<input type="checkbox"/> 700-Thyroid disease		<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):		
DEPENDENT INFO.		<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Patient needs snap-on caps	<input type="checkbox"/> Patient needs Spanish vial labels
		<input type="checkbox"/> Suffix extension if on ID cards	<input type="checkbox"/>		
Name (First, Last)		Date of Birth (MM/DD/YYYY)			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shipping Address (if different than employee/retiree)			Daytime Phone		
			()		
City	State	ZIP Code	Evening Phone		
			()		
E-mail Address		Dr. Name	Dr. Phone (Required)		
			()		
ALLERGIES:		<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> 70-Penicillin	
<input type="checkbox"/> 87-Sulfa		<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):		
HEALTH CONDITIONS:		<input type="checkbox"/> No known	<input type="checkbox"/> 200-Diabetes	<input type="checkbox"/> 300-Hypertension	
<input type="checkbox"/> 400-Heart disease		<input type="checkbox"/> 500-Glaucoma	<input type="checkbox"/> 600-Stomach disorders		
<input type="checkbox"/> 700-Thyroid disease		<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):		



cut here ✂

Customer Care Center:

1-866-855-5446

(TTY: 1-800-573-1833)

Monday-Friday, 7 a.m. – 5 p.m. (Pacific)

Please Note: By submitting this form, you have authorized release of all information to Walgreens Mail Service (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

Thank you for your order.