



Prescriber Fax Form Broward County Government

Intercom WHI
UPI# WHP991



Please print clearly using only **BLACK INK** and **UPPERCASE** letters.

Fill in the applicable circles completely (●).

195

MEMBER OR DEPENDENT: Use this form to have your prescriber submit a medication order or, if you are not yet registered for mail service, you can use this form to register and place your first order. After completing the member and/or dependent, shipping, and payment information, give both pages of the form to your prescriber to complete and fax. Credit card information is required to process your order. **Only faxes sent from a prescriber's office are valid.**

To automatically receive refills of your medications, select Auto Refill. By selecting this option, we automatically refill the prescription(s) at the appropriate time and bill your credit card on file. Most plans allow the convenience of Auto Refill. Check with your plan administrator to see if this is an option for you. As medications may not be returned, if there is a change to your prescription(s), or to discontinue Auto Refill, please notify the Customer Care Center two weeks prior to your next refill date to avoid prescription charges.

PRESCRIBER: Complete the prescription information and fax **BOTH** pages of the form to **Walgreens Mail Service at 888-595-1258**. Most prescription drug plans allow up to a 90-day supply with three refills.

Member Information

Must be completed for each fax order.

Male Female Date of Birth [MM/DD/YYYY] _____

Member ID Number (located on card) _____ Suffix (if on card) _____ Group Number _____

Last Name _____ First Name _____ Middle Initial _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP Code _____

Daytime Phone (____) _____ Evening Phone (____) _____

E-mail Address (to receive information regarding the processing of your order) _____

Dependent Information

Complete only if a prescription is included for the dependent.

Male Female

Date of Birth [MM/DD/YYYY] _____

Suffix (if on card) _____

Group Number _____

Last Name _____

First Name _____

Middle Initial _____

E-mail Address (to receive information regarding the processing of your order) _____

Please Complete To Register

Note: If already registered, indicate any changes to member or dependent allergy and health conditions.

		Allergies			Health Conditions
Member	Dependent		Member	Dependent	
<input type="radio"/>	<input type="radio"/>	Aspirin	<input type="radio"/>	<input type="radio"/>	Arthritis
<input type="radio"/>	<input type="radio"/>	Cephalosporin	<input type="radio"/>	<input type="radio"/>	Asthma
<input type="radio"/>	<input type="radio"/>	Codeine derivatives	<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Morphine derivatives	<input type="radio"/>	<input type="radio"/>	Glaucoma
<input type="radio"/>	<input type="radio"/>	Penicillin	<input type="radio"/>	<input type="radio"/>	Heart disease
<input type="radio"/>	<input type="radio"/>	Sulfa drugs	<input type="radio"/>	<input type="radio"/>	Hypertension
<input type="radio"/>	<input type="radio"/>	None known	<input type="radio"/>	<input type="radio"/>	Pregnancy
<input type="radio"/>	<input type="radio"/>	Other (Use lines below)	<input type="radio"/>	<input type="radio"/>	Thyroid disease
		_____	<input type="radio"/>	<input type="radio"/>	None known
		_____	<input type="radio"/>	<input type="radio"/>	Other (Use lines on left)

Order Preference

- | | | | | | |
|-----------------------|-----------------------|-------------------------|-----------------------|-----------------------|---------------------|
| <input type="radio"/> | <input type="radio"/> | Easy-open caps | <input type="radio"/> | <input type="radio"/> | Spanish vial labels |
| <input type="radio"/> | <input type="radio"/> | Large-print vial labels | <input type="radio"/> | <input type="radio"/> | Auto Refill |

For Separate Shipping, please contact the Customer Care Center at 888-265-1807.

Shipping Information

Must be completed by member. Please allow 14 days for delivery from the date your prescriber faxes in your prescriptions.



196

Total number of prescriptions in this order Total included for copay(s) \$

- Regular Shipping
- Next Business Day (\$17.95) \$
- 2nd Business Day (\$10.95) \$

NO CHARGE

A refill order form and return envelope will be included with your shipment.

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

Total payment charged to credit card \$

Payment Information

Must be completed by member.

We accept American Express®, Discover®, MasterCard®, and Visa®

- Charge credit card on file
- Charge credit card below for this order only
- Place credit card below on file for this and all future orders

Credit Card Number Expiration Date [MM/YY] /

I authorize Walgreens Mail Service to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature _____ Date _____

Prescription Information

IMPORTANT NOTICE: It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens Mail Service will dispense an FDA-approved generic equivalent if available, permitted by your prescriber, and allowed by state law. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at 888-265-1807.

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 refills under your benefit plan.

MUST BE COMPLETED AND SIGNED BY PRESCRIBER. FAX NOT VALID FOR CII PRESCRIPTIONS.

Name of Patient _____ Date of Birth [MM/DD/YYYY] _____

	Drug Name	Strength	Directions	Qty.	# of Refills
1					
2					
3					
4					
5					

Prescriber _____ Substitution Permitted _____ Prescriber _____ Dispense As Written _____

Date _____ DEA# _____

Prescriber Name (Please Print) _____ Prescriber Fax () _____

Prescriber Phone () _____

Confidential Health Information: Health care information is personal information related to a person's health care. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.