

Mail Service Pharmacy Tips

- Complete attached registration form.
- New prescriptions must be mailed to the mail service pharmacy or faxed from your doctor's office on the Walgreens Mail Service doctor fax form.
- 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.
- Your prescription(s) may be filled for up to the plan days supply maximum when allowed by your physician, the law, and in accordance with pharmacy practice. Some medications may only be dispensed for the exact quantity as written by your physician.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted.
- Allow 2 weeks for delivery.

Customer Care Center:

1-866-823-1868 (TTY: 1-800-573-1833)
 Monday-Friday, 8:00 a.m. – 10:00 p.m. (Eastern)
 Saturday-Sunday, 8:00 a.m. – 5:00 p.m. (Eastern)

Refills by Phone:

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

Internet:

www.catalystrx.com

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REGISTRATION & PRESCRIPTION ORDER FORM

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



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Walgreens Mail Service State of Ohio

MEMBER INFO.		<input type="checkbox"/> Male	<input type="checkbox"/> Patient needs snap-on caps	
		<input type="checkbox"/> Female	<input type="checkbox"/> Patient needs Spanish vial labels	
Group Number	S T O H	Intercom	STOH	
		UPI #	SOH001	
ID Number (from card)			<input type="checkbox"/> Suffix if on card	
Name (First, Last)	Date of Birth (MM/DD/YYYY)			
Shipping Address (Please do not use P.O. Box)		Daytime Phone		
City		State	ZIP Code	
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 to advise. <small>04-07</small>	Rx Type	No.	Cost (ea.)	Subtotal
	Generic		\$*	\$
	Brand		\$*	\$
				\$
Credit Card Number				
Credit Card Expiration (MM/YY)		*Please refer to your Plan Document or contact Catalyst Rx for copay amounts.		
Mail to: Walgreens Mail Service P.O. Box 628001, Orlando, FL 32862-8001				

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

Thank you for your order.

DEPENDENT INFORMATION		<input type="checkbox"/> Male	<input type="checkbox"/> Patient needs snap-on caps
		<input type="checkbox"/> Female	<input type="checkbox"/> Patient needs Spanish vial labels
ID No. if on card	<input type="text"/>		Suffix if on card
Name (First, Last)		Date of Birth (MM/DD/YYYY)	
		<input type="text"/>	
Shipping Address (if different than member)		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
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<input type="checkbox"/> 700-Thyroid disease	<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):	

DEPENDENT INFORMATION		<input type="checkbox"/> Male	<input type="checkbox"/> Patient needs snap-on caps
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ID No. if on card	<input type="text"/>		Suffix if on card
Name (First, Last)		Date of Birth (MM/DD/YYYY)	
		<input type="text"/>	
Shipping Address (if different than member)		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
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<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):	

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.

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.

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OhioDAS

Mail Service Pharmacy
Prescription Order Form



Provided in partnership with



