



Prescription Drug Plan: Regence BlueCross BlueShield of Utah

Use this form to register/submit your first prescription order. You can also register at alliancexwp.com **DO NOT** staple, tape or paperclip anything to this form.

Please print clearly using only **BLACK INK** and **UPPERCASE** letters. Fill in the applicable circles completely (●). **Not all ID and Group Number boxes may be needed.**

MEMBER INFORMATION

- Male
- Female

Date of Birth [MM/DD/YYYY] / /

Member ID Number (Located on card)

Email Address (To receive information regarding the processing of your order)

Suffix (If on card)

BIN (Located on card)

PCN (Located on card)

Group Number (Located on card)

Last Name

First Name

Cell Phone

Text Msg* Yes No

 - -

Permanent Address Line 1

Work Phone

 - -

Permanent Address Line 2

Home Phone

 - -

City

State

ZIP Code

Government ID (Most states require ID for controlled Rx substances by law)†

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

 - -
 - -

MEMBER

| Allergies | Health Conditions | Order Preference |
|---|--|--|
| <input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine derivatives <input type="radio"/> Morphine derivatives <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> None known <input type="radio"/> Other (Use lines below) <input type="text"/> <input type="text"/> | <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Glaucoma <input type="radio"/> Heart disease <input type="radio"/> Hypertension <input type="radio"/> Pregnancy <input type="radio"/> Thyroid disease <input type="radio"/> None known <input type="radio"/> Other (Use lines at right) <input type="text"/> <input type="text"/> | <input type="radio"/> Large-print vial labels <input type="radio"/> Spanish vial labels <input type="radio"/> Automatic refill ‡ ‡ Fill in this circle if you would like us to automatically refill your prescriptions in the future. <input type="text"/> <input type="text"/> |

Payment Options

****Please do not send cash**** We accept checks and credit cards.

Checks should be made payable to AllianceRx Walgreens Prime

We accept Visa, MasterCard, Discover and American Express.

Please visit alliancexwp.com to pay by credit card.

You will need to create an account. Go to Settings & Payment then Payment Methods to enter a credit card number.

You can also call our Customer Care Center for assistance at 888-832-5462.

*Standard text message and data rates may apply.

†Driver's license, state ID number, social security number, military ID or passport ID.

**DEPENDENT INFORMATION**

- Male
 Female

Date of Birth [MM/DD/YYYY] / /

For separate shipping, please contact the Customer Care Center toll free at 888-832-5462.

Dependent Last Name

Dependent First Name

Suffix (If on card)

Email address (To receive information regarding the processing of your order)

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

 - -

Prescriber Fax

 - - **DEPENDENT**

| Allergies | Health Conditions | Order Preference |
|---|--|--|
| <input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine derivatives <input type="radio"/> Morphine derivatives <input type="radio"/> Penicillin <input type="radio"/> Sulfa drugs <input type="radio"/> None known <input type="radio"/> Other (Use lines below) | <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Glaucoma <input type="radio"/> Heart disease <input type="radio"/> Hypertension <input type="radio"/> Pregnancy <input type="radio"/> Thyroid disease <input type="radio"/> None known <input type="radio"/> Other (Use lines below) | <input type="radio"/> Large-print vial labels <input type="radio"/> Spanish vial labels |
| <input type="text"/> | <input type="text"/> | |
| <input type="text"/> | <input type="text"/> | |

ORDER INFORMATION – If including a prescription order, please complete this section.

Please allow 10 business days from the time that you place your order to receive your prescription(s). A refill order form and return envelope will be included with your shipment.

Generic equivalents are usually less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. I do not accept a generic equivalent.

By submitting this form, you have authorized release of all information to AllianceRx Walgreens Prime (and other necessary parties) as required to process your order under your benefit plan.

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

- Standard Shipping
 Next Business Day (\$19.95 †)
 2nd Business Day (\$12.95 †)

NO CHARGE\$ \$ Total Payment Due..... \$ Please print your name and date of birth on all prescriptions;
enclose them along with this completed form and mail to:AllianceRx Walgreens Prime
P.O. Box 29061
Phoenix, AZ 85038-9061

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