FAX ORDER FORM

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Walgreens Mail Service

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INTERCOM: ILBC **UPI NO.: BCB 019**

PHYSICIAN: Please fax fully completed form to Walgreens Mail Service: **1-888-595-1258.**
TO THE PATIENT: Please make every attempt to obtain a new written prescription from your **doctor** and send it with an order form and payment to:
Walgreens Mail Service, PO Box 628001, Orlando, FL 32862-8001

If you are unable to make an appointment with your doctor, **follow these steps** to obtain your prescription(s):

1. Fully complete the Member, Patient and Payment Information sections below using **black ink** only. *A credit card number is required at the time the form is submitted.*
2. Have your **doctor** supply the prescription information requested using the prescription form.
3. Have your **doctor** fax the form to the number above. **IMPORTANT: To be valid, the prescription MUST be faxed from your doctor's office.**
4. Please allow 2 weeks for delivery from the date your **physician** faxes your prescription in.

1. MEMBER INFORMATION

Member ID No. -01	Member Date of Birth / /	Group Number (Copy from your ID card)
Member Name (First, Last)	Daytime Phone ( )	Evening Phone ( )
Shipping Address (please do not use P.O. box)	E-mail Address	
City	State	ZIP Code

2. PATIENT INFORMATION

Patient Name (First, Last if different from member)	☐ Male ☐ Female	Patient Date of Birth (Mo/Day/Yr) / /
Patient E-mail Address		

PATIENT ALLERGIES:
☐ No Known ☐ 32-Codeine
☐ 70-Penicillin ☐ 87-Sulfa
☐ 93-Tetracycline ☐ Other (list):

PATIENT HEALTH CONDITIONS:
☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension
☐ 400-Heart Disease ☐ 500-Glaucoma ☐ 600-Stomach Disorders
☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ Other (list):

Dr.'s Name	Dr.'s Phone ( )

3. PAYMENT INFORMATION

PLEASE NOTE: It is standard pharmacy practice to substitute generic equivalents for brand drugs whenever possible. You will receive generic substitutes whenever possible, unless your physician will not allow a generic substitute or you specify otherwise (see below).

☐ By checking this box, I elect to receive brand drugs for all prescriptions in this order whenever possible. By making this choice, I understand that under my benefit plan, I am responsible for any higher payment for each brand drug.

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express) CREDIT CARD EXP. /

I/10-07

Rx FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

☐ SUBSTITUTION PERMISSIBLE, MAY SUBSTITUTE

☐ DISPENSE AS WRITTEN

Dr: _____

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

Facsimile Not valid for CII prescriptions Valid only at Walgreens Mail Service

PLEASE NOTE: By submitting this form, you authorized the release of all information to Walgreens Mail Service (and to other necessary parties) as required to process your prescriptions and their refills under your benefit plan. Blue Cross and Blue Shield's 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).