

For Service Benefit Plan Members

<p>Enter ID # below if not shown or if different from above</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Blue Cross and Blue Shield Federal Employee Program Plan Sponsor or Company Name Prescription</p>	<p>Mail this form to:</p> <p style="text-align: center;">AllianceRx Walgreens Prime P.O. Box 692169 Orlando, FL 32869</p>
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Please use **blue** or **black ink**, CAPITAL LETTERS and fill in **both sides** of this form.

New prescriptions – Mail your new prescriptions with this form.

Number of **New** prescriptions:

Refills – Order online, by phone or write in Rx number(s) below.

Number of **Refill** prescriptions:

For **fastest service**, order refills toll-free at 1-888-346-3731.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

Last name	First name	MI	Suffix (Jr, Sr)
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Street address	Apt/Suite #		<input type="radio"/> Use this address for this order only.
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 50%; height: 20px;" type="text"/>		
City	State	ZIP Code	
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 40%; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>	
Daytime phone #	Evening phone #		
<input style="width: 50%; height: 20px;" type="text"/>	<input style="width: 50%; height: 20px;" type="text"/>		

B Refills. To order refills by mail, enter your prescription number(s) here.

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

On behalf of the Blue Cross and Blue Shield Service Benefit Plan, AllianceRx Walgreens Prime administers the Specialty Pharmacy Program. AllianceRx Walgreens Prime is an independent company that provides specialty drugs to Service Benefit Plan members.

We may package all of these prescriptions together unless you tell us not to.

C Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs: Spanish forms and labels

Last name First name MI Suffix (Jr, Sr)

Nickname Date of birth (MM-DD-YYYY)

Gender: M F - -

Email

Date new prescription was written

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new allergies or health information for this person. Only tell us new information.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other: _____

Health information: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problems
 High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid
 Other: _____

2nd person with a refill or new prescription. This person needs: Spanish forms and labels

Last name First name MI Suffix (Jr, Sr)

Nickname Date of birth (MM-DD-YYYY)

Gender: M F - -

Email

Date new prescription was written

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new allergies or health information for this person. Only tell us new information.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other: _____

Health information: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problems
 High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid
 Other: _____

D Special instructions: _____

E How would you like to pay for this order? Fill in the oval to choose a payment method.

Electronic check. Pay from your bank account. Call Customer Care at 1-888-346-3731.

Credit or debit card. (Visa®, MasterCard®, Discover®, or American Express®)

Fill in this oval to use your card on file.

Fill in this oval to use a new card or to update your card expiration date.

Account #

Exp. Date (MMYY)

Cardholder signature/date

Fill in this oval if you **DO NOT** want to use this payment method for future orders.