℞ FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Healthcare Plus

Dr: _____ DISPENSE AS WRITTEN

Dr: _____ SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

℞ FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Healthcare Plus

Dr: _____ DISPENSE AS WRITTEN

Dr: _____ SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

I/12-03

FAX ORDER FORM
for QualxServ

INTERCOM: QSERV **UPI NO.: QLX 001**

1 0 9

PHYSICIAN: Please fax fully completed form to Walgreens Healthcare Plus: **1-800-332-9581.**
TO THE PATIENT: Walgreens Healthcare Plus is your mail service pharmacy.
Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Walgreens Healthcare Plus, P.O. Box 29061, Phoenix, AZ 85038-9061
Customer Service: 1-800-345-1985 (TTY for hearing impaired: 1-800-573-1833)

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

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 prescriber's 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.

PLEASE NOTE: By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

1. MEMBER INFORMATION

Member ID Number	Member Date of Birth
	/ /

Member Name (First, Last)	Daytime Phone	Evening Phone
	( )	( )

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:		PATIENT HEALTH CONDITIONS:		
☐ No Known	☐ 32-Codeine	☐ No Known	☐ 200-Diabetes	☐ 300-Hypertension
☐ 70-Penicillin	☐ 87-Sulfa	☐ 400-Heart Disease	☐ 500-Glaucoma	☐ 600-Stomach Disorders
☐ 93-Tetracycline	☐ Other (list):	☐ 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-name drugs whenever possible. Walgreens Healthcare Plus 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 Service number to advise.

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

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