



Registration and Prescription Order Form
Priority Health



991000PRIORPRY001

Use this form to register/submit your first prescription order. You can also register at WalgreensMail.com/easy. 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.

CONTRACT HOLDER INFORMATION

- Male
Female

Date of Birth [MM/DD/YYYY]

Intercom: PRIOR

UPI#: PRY001

Contract Holder ID Number (Located on card)

Suffix (If on card)

Group Number

[ID Number input boxes]

[Suffix input boxes]

[Group Number input boxes]

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

[Email Address input boxes]

Last Name

First Name

[Last Name input boxes]

[First Name input boxes]

Permanent Address 1

[Permanent Address 1 input boxes]

Daytime Phone

[Daytime Phone input boxes]

Permanent Address 2

[Permanent Address 2 input boxes]

Evening Phone

[Evening Phone input boxes]

City

State

ZIP Code

[City input boxes]

[State input boxes]

[ZIP Code input boxes]

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

[Prescriber Last Name input boxes]

[Prescriber First Initial input boxes]

[Prescriber Phone input boxes]

[Prescriber Fax input boxes]

CONTRACT HOLDER

Table with 3 columns: Allergies, Health Conditions, Order Preference. Includes checkboxes for various medical conditions and preferences.

Payment Options

Payment is required at time of order. Please do not send cash.

We accept American Express, Discover, MasterCard and Visa.

- Check made payable to Walgreens Mail Service
Charge credit card below for this order only
Place credit card below on file for this and all future orders

Credit Card Number [input boxes]

Expiration Date [MM/YY] [input boxes]

I authorize Walgreens Mail Service to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature [input line] Date [input line]

