

FAX ORDER FORM TO:

1-888-830-3608

To the Physician: Please fax this form to WellDyneRx to help facilitate this member's mail order prescriptions.

To the patient: 1) Fully complete the patient and Cardholder information requested below. 2) Have your doctor supply the prescription information requested using the Rx form on the left. 3) Ask your doctor to fax this form to the fax number shown above. 4) A credit card number is required at the time the form is submitted.

PATIENT INFORMATION

Patient Last Name	Patient First Name	Gender	Birth Date
List Allergies:			None
1.	2.	3.	
Physician Last Name	Physician First Name	Physician Telephone	

CARDHOLDER INFORMATION

Member Last Name	Member First Name	Gender	Birth Date
Mailing Address			
Group Number	SSN / ID#	Telephone Number	

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 the higher brand co-payment for each drug.

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

DUE TO FEDERAL REGULATIONS WELLDYNERX CAN ONLY ACCEPT PRESCRIPTIONS FROM YOUR DOCTOR

For: _____ Date: _____
 Address: _____ Phone: _____
RX

Dr. _____ Dr. _____
 Dispense as Written Substitution Allowed

Physician Name (Please Print): _____
 Refill: _____ Address: _____
 DEA #: _____ Telephone #: _____

For: _____ Date: _____
 Address: _____ Phone: _____
RX

Dr. _____ Dr. _____
 Dispense as Written Substitution Allowed

Physician Name (Please Print): _____
 Refill: _____ Address: _____
 DEA #: _____ Telephone #: _____