



Monday – Friday
8:00 A.M. – 5:00 P.M.

PO Box 4517
Englewood, CO 80155-4517
Denver Metro: 303-793-9954
Toll Free: 888-479-2000
Fax: 303-793-0925
www.welldynrx.com



Mail Service Order Form (Medicare Part D Only)

Employer's Name			Group Number
Employee's Last Name	Middle Initial	First Name	Employee's SSN
Address		Apt. #	Daytime Phone Number
City	State	Zip Code	

Prescriptions Requested For: (Check All That Apply)

- When faxing in order form, prescriptions must be called or faxed in by your physician.
- You may also mail this form in with original prescription.

First & Last Name	Date of Birth	# of Rx's Enclosed
<input type="checkbox"/> Employee		
<input type="checkbox"/> Spouse		
<input type="checkbox"/> Son		
<input type="checkbox"/> Daughter		
<input type="checkbox"/> Other		

Patient Profile

Gender	First & Last Name	Allergies	Medical Condi- tions	Physician's Name	Physician's Phone #

Method of Payment

Visa MasterCard Discover American Express

Credit Card Number _____ Expiration Date _____

Credit Card Will Be Used For All Future Orders

_____ Date _____

(Signature For Credit Card Authorization)

Acknowledgment

I understand that when permitted by law, WellDyne RxWest will substitute an FDA approved, therapeutic equivalent generic drug for any brand name medications requested with this order unless prohibited by me in writing or the prescribing physician. For all prescriptions submitted, I certify that I or my family members are eligible to receive prescriptions under this plan. I will take personal responsibility for payment for all medications that I or my family members receive.

Signature _____ Date _____

* Please note that for controlled substances, we are required by law to have the original prescription on file.