HOW TO ORDER

New Prescriptions

Fill out this order form completely. Enclose the original prescription(s) your doctor gave you and your payment in the envelope provided.

Unless otherwise noted by you, Wellpartner will fill your prescriptions for the quantities prescribed as written by your doctor.

Refill Prescriptions

You may order your Wellpartner prescription refill(s) by mail using this order form. Or, choose from telephone, fax or internet options to place your refill order(s).

Prescriptions at Other Pharmacies

If you have prescriptions that are currently being filled by another pharmacy, please have your doctor or nurse practitioner fax or call Wellpartner with all of the prescriptions that are needed now. Doctor can fax prescriptions to Wellpartner at 1-866-624-5797. Or, if you have a new prescription, you can enclose that prescription with this order form.

Shipping Charges

Standard shipping is FREE on all orders containing prescription items. Orders containing only non-prescription items will be charged a $3.95 fee for standard shipping. Next-day and second-day delivery are available for an additional charge.

Payment Options

Full payment is required at the time of order. Payment options include:

- Check
- Money Order
- Credit Card (DISC, VISA, MC, AMEX)

Delivery Time

Our goal is for you to receive your shipment within four to seven business days from the date we receive your order.

Generic Drugs

Our pharmacists will substitute a less expensive generic medication for the brand-name medication your doctor prescribed, unless you or your doctor indicate otherwise. We utilize only FDA-approved generic medications that meet rigid quality and equivalence guidelines.

Confidentiality

In order to more effectively monitor your prescription drug therapy and better serve you, we have requested personal information such as your date of birth, medical conditions, and known drug allergies. This information, as well as all personal information retained by Wellpartner, is strictly confidential and will only be used to help us provide you with the utmost in pharmacy care.

Patient Information

Last Name _____

First Name _____ MI _____

Date of Birth _____ ☐ Male ☐ Female

Primary Prescriber _____

Prescriber Phone # _____

Medical Record # (if applicable) _____

Allergies (Check all that apply)

☐ None known ☐ Aspirin ☐ Codeine

☐ Erythromycin ☐ Penicillin ☐ Morphine ☐ Sulfa

Other _____

Medical Conditions (Check all that apply)

☐ None known ☐ Active Ulcer ☐ Arthritis

☐ Asthma ☐ Congestive Heart Failure ☐ Diabetes

☐ High Blood Pressure ☐ Hyperthyroid

☐ Hypothyroid ☐ Kidney Disorder ☐ Liver disorder

Other _____

Shipping Information

☐ Permanent address ☐ Address for this order only

Address _____

_____

City _____ State _____ Zip _____

Daytime Phone _____

E-mail Address _____

Prescription Insurance Information

Insurance plan _____

Group name/number _____

Cardholder ID number _____

Primary cardholder name _____

Relationship to cardholder: ☐ Self ☐ Spouse ☐ Child/Dependant

Insurance phone # _____
(refer to back of insurance card).

Insurance customers: *Please note, your prescriptions will be filled in accordance with your plan limitations. If you have any questions, please contact your benefits coordinator.*

Payment Information

☐ Check enclosed ☐ Credit card ☐ Money Order

☐ DISCOVER NOVUS ☐ VISA ☐ MasterCard ☐ American Express Cards

Credit card number _____

Expiration date _____

Name on card _____

Signature of cardholder _____

Generic Preference

See reverse side for our generic policy.

Generics OK? ☐ Yes ☐ No

Note: *Checking no may result in higher prices or copays. Some plans require prescriptions to be filled using a generic alternative. In all cases, we will conform to your plan s limitations.*

Safety Cap Preference

Federal Law requires us to dispense your medication with a child-resistant cap. If you do **NOT** want to receive your medications with child-resistant caps, please sign below.

Signed _____

Prescription Items (new, refill & transfer)

	(**For transfers**) Pharmacy Name & Phone number	Prescriber Name & Phone number	Rx #	Medication Name & Strength	Qty.	Price/ Copay
1						
2						
3						
4						

Non-Prescription Items

Item #	Item Description	Qty.	Price Each	Total Price
	Shipping Charge (see reverse for shipping charge information):			
	TOTAL AMOUNT OF ORDER:			