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.

For: _____ Date: _____

Address: _____ Ph: _____

RX

QTY for 90 Days:

_____

Dosage Form

_____

Sig Line: _____

Dr. _____ Dr. _____
Dispense as Written Substitution Allowed

Physician Name (Please Print): _____

Refill: _____ Address: _____

NPI#: _____ DEA #: _____ Ph#: _____

For: _____ Date: _____

Address: _____ Ph: _____

RX

QTY for 90 Days:

_____

Dosage Form

_____

Sig Line: _____

Dr. _____ Dr. _____
Dispense as Written Substitution Allowed

Physician Name (Please Print): _____

Refill: _____ Address: _____

NPI#: _____ DEA #: _____ Ph#: _____

PATIENT INFORMATION

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

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