



PRESCRIPTION DRUG PROGRAM MAIL SERVICE FORM

Mail Order Prescriptions Made Easy!

The Mail Service Enrollment Form is only needed for first time orders, dependents who have been added since the last order, or changes to current information.

To start your Mail Service Benefit, use one of the following convenient steps:

Option 1

Enroll online at www.myWDRX.com. Mail your prescriptions to WellDyneRx or have your prescriber fax them to us at 888-830-3608.

– OR –

Option 2

Enroll by completing this form and mail it back to WellDyneRx. Include your prescriptions or have your prescriber fax them to us at 888-830-3608.

Please Note: Only prescribers may fax prescriptions to a pharmacy.



WellDyneRx

PO Box 4517
Englewood, CO 80155-4517
Toll-Free: 888-479-2000
Toll-Free Fax: 888-830-3608
www.myWDRX.com

MAIL SERVICE ENROLLMENT FORM

Cardholder's Last Name <input type="text"/> Primary Address <input type="text"/> Shipping Address (if different than Primary Address) <input type="text"/> Primary Phone <input type="text"/> - <input type="text"/> - <input type="text"/> Group Name (Primary) <input type="text"/> Group Name (Secondary) <input type="text"/> Please Charge My: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express Credit Card #: <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> Cardholder's Name: <input type="text"/>	First Name <input type="text"/> City <input type="text"/> City <input type="text"/> Secondary Phone <input type="text"/> - <input type="text"/> - <input type="text"/> Group ID# <input type="text"/> Group ID# <input type="text"/> Expiration Date <input type="text"/> / <input type="text"/> Signature* <input type="text"/>	Middle Initial <input type="text"/> State <input type="text"/> State <input type="text"/> Member ID# <input type="text"/> Member ID# <input type="text"/>
Date of Birth (mm/dd/yy) <input type="text"/> / <input type="text"/> / <input type="text"/>		

*Credit Card Will Be Used For All Future Orders.

Remember to write your Member I.D. and Date of Birth on your prescriptions.
 Once WellDyneRx has received all necessary information, orders will ship within 2 to 3 business days.

PATIENT PROFILE

Member Information

DRUG Allergies

Name	M	M	Date of Birth				Male/Female(M/F)	None	Amoxicillin	Aspirin	Cephalosporins	Codeine	Erythromycin	Penicillin	Sulfa	Tetracyclines	Other (Please Specify)	
			D	D	Y	Y												
Primary Cardholder's First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Spouse's First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Dependent's First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Dependent's First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Dependent's First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Dependent's First Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please enclose additional family member information on a separate piece of paper.

Acknowledgement: WellDyneRx will substitute FDA approved generic equivalent drugs for any brand name medication(s) ordered unless specified by the prescriber or me on each prescription. I will take personal responsibility for payment of all medications that I or my family members receive.

Remember to write your Member I.D., Date of Birth, Brand/Generic preference and Fill Now or Hold on each prescription sent in.

Signature _____

Date _____



Enclose with prescription(s)

HOW TO ORDER NEW MEDICATION

Complete the attached form to begin ordering your maintenance prescription medications from WellDyneRx mail service pharmacy. This form is only needed for new members, first time orders, or dependents that have been added since the last order. Be sure to complete your method of payment.

Include the form and any prescriptions you may have in the attached envelope. Remember to write your Member I.D. and Date of Birth on your prescriptions.

WellDyneRx will dispense the days supply as written by the prescriber. For example, if your prescription is written for 30 days and your plan allows 30 day fills at mail order, WellDyneRx will fill the 30 day supply as written. If your prescription is written for 30 days, and your plan only allows 90 days, we will contact you regarding the status of your order and how to best meet your needs.

To save time, please look at your prescription before you leave your prescriber's office. Check the drug name, quantity and days supply. The days supply should match the number of days you want us to provide with each refill. Please review your Plan benefits for the maximum days supply your Plan will allow with each mail order fill.

HOW TO ORDER REFILLS

To place a refill order, please visit www.myWDRX.com or call 888-479-2000 **prompt 2** approximately three weeks prior to completion of your medication supply.

To learn more about our Mail Service Pharmacy, please visit our web site at www.myWDRX.com or call us at 888-479-2000.

SAVINGS

Mail Service can save you money. To find out the cost for your mail order medication, contact our Member Services team.

Where appropriate, WellDyneRx uses generic medications to fill your prescriptions. The FDA requires that all drugs be safe and effective. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risks and benefits as their brand name counterparts.

QUALITY IS OUR FIRST PRIORITY

The WellDyneRx Mail Service Pharmacy is staffed by registered pharmacists and certified pharmacy technicians. With advanced robotics and state-of-the-art technology, our highly trained professionals conduct multiple quality and accuracy checks on your order.

Your prescription order will be shipped using US Mail or UPS. Refrigerated items are shipped in accordance with FDA and Manufacturers specifications. For your security, some controlled substances are shipped UPS Ground with a tracking number and may require a signature.