PRESCRIPTION DELIVERY SERVICE FORM
Mail Order Prescription Deliveries Made Easy!

This form is only needed for first-time orders, dependents who have been added since the last order, or changes to current information.

How to Order New Medication

Enroll using one of the following options.

Option 1: Online at **www.myWDRx.com.** Mail your prescriptions to WellDyneRx, or have your **prescriber** fax them to 888-830-3608 or e-prescribe them to WellDyneRx FL or WellDyneRx CO.

Option 2: Complete this form and mail it back to WellDyneRx, PO Box 4517, Englewood, CO 80155-4517.

Write your **Member ID** and **Date of Birth** on your prescriptions.

Mail your prescriptions or have your **prescriber** fax them to 888-830-3608 or e-prescribe to WellDyneRx FL or WellDyneRx CO. **Please Note: Only prescribers may fax prescriptions to a pharmacy.**

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 about your order.

Please check your prescription for drug name, quantity and days supply before you leave your prescriber's office. 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 refill.

How to Order Refills

To place a refill order, please visit www.myWDRx.com, or have your doctor e-prescribe approximately three weeks before you will finish your medication supply. For quickest processing, have your prescriber submit an electronic prescription to: WellDyneRx FL or WellDyneRx CO.

Savings

Prescription Delivery Service can save you money. To find out the cost for your medication, please visit **www.myWDRx.com**.

Where appropriate, WellDyneRx uses generic medications to fill your prescriptions.

Quality Is First Priority

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.

Contact Information

WellDyneRx
PO Box 4517, Englewood, CO 80155-4517
Toll-Free Phone: 888-479-2000
Toll-Free TTY: 800-900-6570
Toll-Free Fax: 888-830-3608
www.myWDRx.com

Hours of Operation: 24 hours a day, 7 days a week

PRESCRIPTION DELIVERY SERVICE ENROLLMENT FORM

Subscriber's Last Name | First Name | Middle Initial | Date of Birth (mm/dd/yy) __/__/__

Primary Address | City | State | Zip Code

Shipping Address (if different than Primary Address) | City | State | Zip Code

Home Phone ___-___-____ | Cell Phone ___-___-____ | E-mail Address

Contact Preference: ❑Phone call ❑E-mail ❑Text

Group Name (Primary)

Group ID# | Member ID#

Group Name (Secondary)

Group ID# | Member ID#

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PATIENT PROFILE

It is your responsibility to complete this section accurately. If you do not complete this section, WellDyneRx will assume you have none of these drug allergies or disease states listed and will note Patient Drug Allergies and Disease States as "NONE". You may update this information at any time by calling Member Services at 1-888-479-2000.

Patient Information			Drug Allergies										Health Conditions									
	DATE OF BIRTH M M DD Y Y Y Y	Male/Female M F	None	Amoxicillin	Aspirin	Cephalosporins	Codeine	Erythromycin	Penicillin	Sulfa	Tetracyclines	Other (Specify)**	None	Asthma	Bleeding Disorder	COPD	Depression	Diabetes	GERD/Ulcer	High Cholesterol/Heart Disease	Hypertension	Liver Disease	Renal Disease
1. Primary Subscriber's First Name																						
2. Spouse's First Name																						
3. Other Dependent's First Name																						
4. Other Dependent's First Name																						
5. Other Dependent's First Name																						
6. Other Dependent's First Name																						

**Please Specify Patient and Other Drug Allergies

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)

WELLDYNERX WILL CONTACT YOUR PRESCRIBER FOR NEW PRESCRIPTIONS

Complete this section only if requesting new mail order prescription(s) from your prescriber. We substitute generics on prescriptions unless otherwise noted by your prescriber.

Patient Name	Date of Birth	Medication Name and Strength	Prescriber's Name, Phone Number and Fax Number

Once WellDyneRx has received all necessary and correct information, orders will ship within 2 to 3 business days.

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