# PRESCRIPTION DRUG PROGRAM
# MAIL SERVICE FORM
## Mail Order Prescriptions Made Easy!

## How to Order New Medication

This form is only needed for first time orders, dependents who have been added since the last order and who require a prescription to be filled via mail order, or changes to current information. Be sure to complete your method of payment on line at emhp.welldynrex.com when you enroll.

To begin ordering your maintenance prescription medications from the WellDyneRx Mail Service Pharmacy, enroll using one of the following options.

***Option 1***
Enroll online at **emhp.welldynerx.com.** Mail your prescriptions to WellDyneRx or have your **prescriber** fax them to 877-221-1259 or e-prescribe to: NCPDP ID #: 1035371 P.O. Box 90369 Lakeland, FL

***Option 2***
Enroll by completing this form and mailing it back to WellDyneRx in the envelope provided, or mail to WellDyneRx, PO Box 90369, Lakeland, FL 33804-0369.

Include your prescriptions in the envelope or have your **prescriber** fax them to 877-221-1259 or e-prescribe to NCPDP ID #: 1035371 P.O. Box 90369 Lakeland, FL

Remember to write your **Identification Number** and **Date of Birth** on your prescriptions.

**Please Note: Only prescribing physicians 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 22-90 days, WellDyneRx will fill the 22-90 day supply as written.
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 refill.

## How to Order Refills

To place a refill order, please visit **emhp.welldynerx.com** or call **855-799-6831** approximately three weeks prior to depletion of your medication supply.

## Savings

Mail Service can save you money. To find out the cost for your mail order medication, please visit **emhp.welldynerx.com**.

Since your plan has a mandatory generic requirement, WellDyneRx will dispense the FDA approved generic equivalent for brand medications whenever possible, unless your physician indicates otherwise. Brand-name medications may be subject to a higher cost. 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 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.

## Contact Information

**WellDyneRx**
PO Box 90369, Lakeland, FL 33804-0369
Toll-Free Phone: 855-799-6831
Toll-Free TTY: 800-900-6570
Toll-Free Fax: 877-221-1259
emhp.welldynerx.com
**Hours of Operation: 24 hours a day, 7 days a week**

## Mail 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

Group Name (Primary) | WDRXGRP | Identification Number

Group Name (Secondary) | WDRXGRP | Identification Number

**Contact Preference:** ❑Phone ❑Email

# 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 1-855-799-6831.

| 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 prescribing physician on each prescription. I will take personal responsibility for payment of all medications that I or my family members receive.

***Remember to write your Identification Number, Date of Birth, and Fill Now or Hold on each prescription sent in. If "Hold" is not written on the front of your prescription, your medication will be filled immediately***

Signature _____ Date _____