WELLPARTNER®
Expanding Community Benefit and Patient Care

Prescription Mail Order

Wellpartner works with Express Scripts, your pharmacy benefits manager, to provide mail order pharmacy services.

We provide free standard shipping for all prescription orders. This includes any nonprescription (OTC) items ordered at the same time. You can expect your order to arrive about seven to ten business days after we receive it. Please allow extra time for new prescriptions.

Instructions:

- Please fill out all sections of the form below and mail it with your new prescription(s).
- Make sure the patient's first and last name, address, and date of birth are printed on each prescription.
- If there are multiple providers listed on a prescription, circle or clearly mark the provider that wrote each prescription. Please do not add any other marks to the prescription.
- Be sure to enclose your original prescription(s).

To order by mail, send the order form attached along with your original prescription(s) to:

Wellpartner
P.O. Box 5909
Portland, OR 97228-5909

To order by phone, call 1-877-935-5797.

To order online, go to Wellpartner.com.

Please Note: Your prescriptions will be filled according to your plan benefits. If you have questions, please contact Amerigroup Community Care Member Services at 1-800-600-4441 (TTY: 711).

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Patient Information		
Last Name:	First Name:	MI:
Date of Birth: / /	Gender:	
[Health plan name] ID number:		
Shipping Information ☐ Permanent Address ☐ Address for this order only		
Address:		
City:	State:	ZIP:
Daytime Phone:	Email Address:	

Allergies (Check all that apply)				
☐ None known	☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Penicillin
☐ Morphine	☐ Sulfa	☐ Other:		

Medical Conditions (Check all that apply)		
☐ None known	☐ HIV	☐ Arthritis
☐ Asthma	☐ Congestive Heart Failure	☐ Diabetes
☐ High Blood Pressure	☐ Hyperthyroid	☐ Hypothyroid
☐ Kidney Disorder	☐ Liver Disorder	☐ Other:
Primary Provider Name:		
Provider Phone:	Provider Fax:	

Payment Information (if a payment is due for your order, the payment information below must be provided before your order can be shipped)			
☐ Credit Card ☐ Debit Card			
☐ Discover	☐ Visa	☐ Master Card	☐ American Express
Card Number:	Expiration Date (mm/yy):	CVV#:	
Name on Card:	Cardholder Signature:		

Generic Preference:
Our pharmacists will substitute a less expensive generic medication for any brand-name medication your provider prescribes.

Security 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: _____