

For: _____ Date _____
 Address: _____ Phone _____

RX

Dr: _____ Dr. _____
 Dispense as Written Substitution Allowed

Physician Name (Please Print) _____

Refill _____ Address _____

DEA# _____ Telephone # _____

WellCare Medicare Part D Member Mail Order Prescription Form:

WellDyneRx
 500 Eagles Landing Drive
 Lakeland, FL 33810
 888-479-2000

FAX ORDER FORM TO: 1-877-221-1259

PATIENT INFORMATION

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

For: _____ Date _____
 Address: _____ Phone _____

RX

Dr: _____ Dr. _____
 Dispense as Written Substitution Allowed

Physician Name (Please Print) _____

Refill _____ Address _____

DEA# _____ Telephone # _____

CARDHOLDER INFORMATION

Member Last Name	Member First Name	Gender	Birth Date
Mailing Address			
Group Number	WellCare ID #	Telephone number	

DUE TO FEDERAL REGULATIONS WELLDYNERX PHARMACY CAN ONLY ACCEPT PRESCRIPTIONS FROM PHYSICIANS