

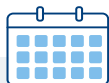
Mail Order Pharmacy



Delivery Convenience

Our Mail Order Pharmacy offers you convenient delivery of your medications. We recommend you use this service if you take a medication on an ongoing basis.

Here's why:



You get a two-month supply, so you don't have to refill each month.

Tip: This can help you save gas and time. No trips to the pharmacy! No waiting in line!




We'll remind you when it's time to refill, so you don't run out of your medication.

Tip: We will remind you by phone and email. You can easily refill your medication online or by phone.

To get started with Mail Order Pharmacy, you must register on www.WellDyne.com. If you haven't already done this, here's how:

1. Go to www.WellDyne.com. Click "**For Members.**"
2. Enter your Member ID, name, and date of birth.
3. Create a user name and password for your account and log into the portal.
4. If you will be using our Mail Order Pharmacy:
 - Let us know about any allergies or health conditions.
 - Verify your shipping address.
 - Provide a payment method (credit, debit, FSA or HSA card) to speed up the ordering process.

The WellDyne Mail Order Pharmacy offers free delivery of medications to a convenient place – home, work, or doctor's office.



For questions about your pharmacy benefits, visit our member portal at www.WellDyne.com and click "For Members."
Or call Member Services at the number listed on your ID card.



Mail Order Pharmacy Registration Form

Please use this form to register, add dependents, or update information. Send completed form to WellDyne, P.O. Box 90369, Lakeland, FL 33804.

Insurance Cardholder Information

Last Name		First Name		Mid Initial	Date of Birth
Billing Address			City	State	Zip Code
Shipping Address (Same as Billing Address)			City	State	Zip Code
Home Phone	Cell Phone	Email Address (to receive information about your prescription orders)			
Group Name (Primary)			Group Name (Secondary)		
Group ID#	Member ID#	Group ID#	Member ID#		

Allergies and Health Conditions

For your safety, WellDyne requires allergy and health condition information for you and your dependents before dispensing medication. Please enclose additional family member information on a separate piece of paper.

Cardholder Information			Dependent Information			Dependent Information		
First and Last Name:			First and Last Name:			First and Last Name:		
Date of Birth:			Date of Birth:			Date of Birth:		
Male	Female		Male	Female		Male	Female	
Relationship to Cardholder:			Relationship to Cardholder:			Relationship to Cardholder:		
Drug Allergies	Health Conditions		Drug Allergies	Health Conditions		Drug Allergies	Health Conditions	
No Known	No Known		No Known	No Known		No Known	No Known	
Amoxicillin	Asthma		Amoxicillin	Asthma		Amoxicillin	Asthma	
Aspirin	Bleeding Disorder		Aspirin	Bleeding Disorder		Aspirin	Bleeding Disorder	
Cephalosporins	COPD		Cephalosporins	COPD		Cephalosporins	COPD	
Codeine	Depression		Codeine	Depression		Codeine	Depression	
Erythromycin	Diabetes		Erythromycin	Diabetes		Erythromycin	Diabetes	
Penicillin	GERD/Ulcer		Penicillin	GERD/Ulcer		Penicillin	GERD/Ulcer	
Sulfa	Heart Disease		Sulfa	Heart Disease		Sulfa	Heart Disease	
Tetracyclines	High Cholesterol		Tetracyclines	High Cholesterol		Tetracyclines	High Cholesterol	
Other* (List below)	Hypertension		Other* (List below)	Hypertension		Other* (List below)	Hypertension	
	Liver Disease			Liver Disease			Liver Disease	
	Renal Disease			Renal Disease			Renal Disease	
*Please specify patient and other drug allergies:								

Medication Preference: WellDyne will substitute generic equivalent drugs for brand medications ordered if available and permitted by your doctor. A generic drug has the same effectiveness, quality, safety, and strength, as confirmed by the FDA.

Please indicate your preference for brand or generic drugs. If no box is checked, WellDyne will substitute generic drugs.

Substitute generic drugs if available and permitted by my doctor.

I want to receive brand medications only. I understand that brand medications may be more expensive.

Signature	Date
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