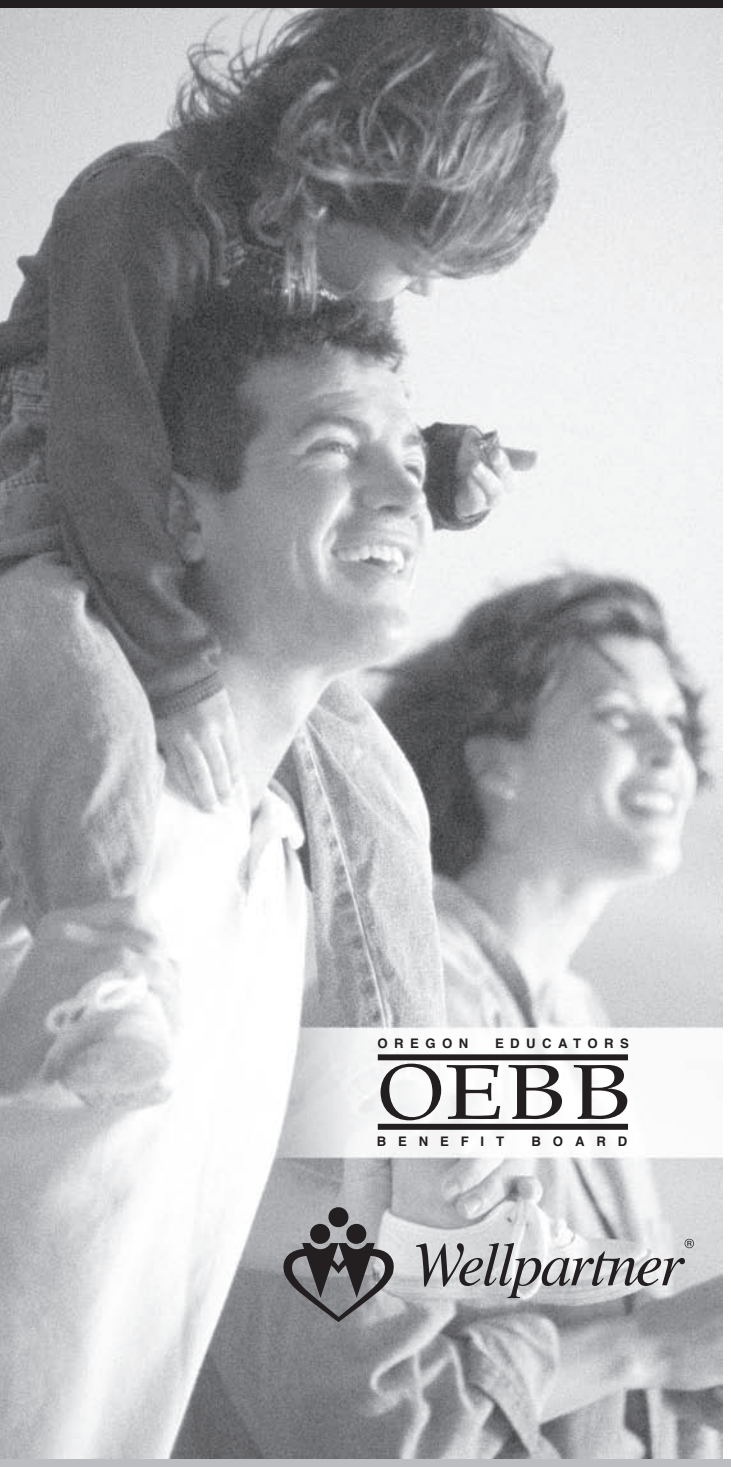

How to Order

New Prescriptions

To avoid delays, please make sure to complete all sections of this form. Then mail it, along with your new prescriptions and payment, to Wellpartner. Ask your health care provider to write your prescription to maximize your prescription drug benefit. Usually, this means your prescription may be written for up to a 90-day supply of your medication. Check your prescription plan for specific coverage information.

Or you may register the information required on this form (or make changes to this information) via our secure website at www.wellpartner.com. **After** registration is complete, your doctor may fax prescriptions to Wellpartner at 1-866-624-5797.

Please do not send prescriptions or have your doctor fax prescriptions to Wellpartner until you want them filled. Unless you notify us differently, Wellpartner will fill your prescriptions for the quantities prescribed by your doctor and allowed by your prescription plan benefit.

Shipping Charges

Standard shipping is FREE on all orders containing prescription items. Orders containing only non-prescription items will be charged a $5.95 fee for standard shipping. Next-day and second-day delivery are available for an additional charge.

Payment Options

Payment is required before your order can be shipped. Payment is accepted in the form of a credit card (American Express, Discover, MasterCard or Visa) or a debit card.

Delivery Time

In most cases your prescription order will arrive within 4 to 7 business days after your order is received by Wellpartner. **Please allow more time for new prescriptions**.

Generic Drugs

Our pharmacists will substitute a less expensive generic medication for the brand-name medication your doctor prescribed, unless you or your doctor indicate otherwise.We utilize only FDA-approved generic medications that meet rigid quality and equivalence guidelines.

Confidentiality

In order to more effectively monitor your prescription drug therapy and better serve you, we have requested personal information such as your date of birth, medical conditions, and known drug allergies. This information, as well as all personal information retained by Wellpartner, is strictly confidential and will only be used to help us provide you with the utmost in pharmacy care.

0 6 0 8 0 1 0 1 0 0 0 E B B 0

Instructions

Please complete this form and return it to Wellpartner, P.O. Box 5909, Portland, OR 97228-5909. Be sure to enclose your original prescription(s) along with payment information.

- To avoid delays, please complete all sections of this form and mail it with your new prescriptions.
- **Please do not send prescriptions to Wellpartner until you want them filled**. Upon receipt of your order Wellpartner will fill your prescriptions in accordance with the provisions of your prescription drug plan.
- Make sure the patient's first name, last name, address and date of birth are printed on **each prescription**.
- If there are multiple doctors listed on a prescription, circle or clearly mark the doctor that wrote each prescription.
- Payment is required before your order can be shipped.

Patient Information

Last Name _____

First Name _____ MI _____

Date of Birth _____ ☐ Male ☐ Female

Primary Prescriber _____

Prescriber Phone # _____

Medical Record # (if applicable) _____

Allergies (Check all that apply)

☐ None known ☐ Aspirin ☐ Codeine

☐ Erythromycin ☐ Penicillin ☐ Morphine ☐ Sulfa

Other _____

Medical Conditions (Check all that apply)

☐ None known ☐ Active Ulcer ☐ Arthritis

☐ Asthma ☐ Congestive Heart Failure ☐ Diabetes

☐ High Blood Pressure ☐ Hyperthyroid

☐ Hypothyroid ☐ Kidney Disorder ☐ Liver Disorder

Other _____

Shipping Information

☐ Permanent address ☐ Address for this order only

Address _____

_____

City _____ State _____ Zip _____

Daytime Phone _____

E-mail Address _____

Prescription Insurance Information

Insurance plan _____

Group name/number _____

Cardholder ID number _____

Primary cardholder name _____

Relationship to cardholder: ☐ Self ☐ Spouse/Partner ☐ Child/Dependent

Insurance Phone # _____
(refer to back of insurance card)

Please note, your prescriptions will be filled in accordance with your plan limitations. If you have any questions, please contact your benefits coordinator.

Payment Information

☐ Credit Card ☐ Debit Card

☐ DISCOVER ☐ VISA ☐ MasterCard ☐

Card number _____

Expiration date _____

Name on card _____

Signature of cardholder _____

Generic Preference

Generics OK? ☐ Yes ☐ No

Note: Checking no may result in higher prices or copays. Some plans require prescriptions to be filled using a generic alternative. In all cases, we will conform to your plan's limitations.

Safety Cap 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 _____