



# Prescription Delivery Service Information



Prescription Delivery Service offers free delivery of medications to a convenient place – home, work, or doctor’s office. We recommend this service if you take a medication on an ongoing basis. Here’s what you need to know to use the service.

## ENROLLING

Get started by enrolling for Prescription Delivery Service. You’ll need to provide insurance, contact, payment, and health information for you and your covered dependents.

**Online:** For 24/7 access to your benefit and prescription information, enroll at <https://hne.welldynernx.com>.

**By Mail:** Complete the Prescription Delivery Service Enrollment Form and mail to:

**WellDyneRx, P.O. Box 90369, Lakeland, FL 33804**

If you enroll by mail, please call Member Services to provide payment information for your orders. Payment is required in full at the time of order for most plans.

**By Phone:** Call Member Services at 1-888-479-2000.

## SENDING PRESCRIPTIONS

Your doctor must write your prescription for a 90-day supply (or the number of days your plan allows for mail service). There may be limitations on some medications, such as controlled medications, due to state and federal laws. Send your prescriptions to WellDyneRx:

**Electronically:** This is the quickest way to fill your prescription. Ask your doctor to electronically send your prescription to WellDyneRx Prescription Delivery.

**Fax:** 1-888-830-3608 or 1-877-221-1259  
Only prescribers may fax prescriptions to a pharmacy.

**By Mail:** Write your Member ID and patient’s date of birth on the prescriptions, and mail original prescriptions to:

**WellDyneRx, P.O. Box 90369, Lakeland, FL 33804**

## ORDERING PRESCRIPTIONS

WellDyneRx offers several easy ways to order your prescriptions. We will send a reminder when it’s time to refill your prescription. The best time to order refills is when you have a 14-day supply of your medicine left.

**Online:** Order refills at <https://hne.welldynernx.com>.

**By Mail:** Mail the reorder form included in every prescription shipment or original prescriptions with Member ID and patient’s date of birth to:

**WellDyneRx, P.O. Box 90369, Lakeland, FL 33804**

**By Phone:** Call Member Services at 1-888-479-2000.

## PAYMENT

Payment is required with every prescription order. WellDyneRx accepts Visa, MasterCard, American Express, Discover, check, check by phone, or money order. We also accept payment cards for flexible spending and health savings accounts. For your convenience, we can keep your payment card on file for future orders by adding it to your secure online account. Enter your payment card information online or call Member Services.

## MEDICATION PREFERENCE

WellDyneRx substitutes FDA-approved generic equivalent drugs for any brand name medications ordered, if available and permitted by your doctor. A generic drug is a variation of a brand name that has the same effectiveness, quality, safety, and strength, as confirmed by the FDA. If you prefer to receive only brand medications and pay the additional cost, please contact Member Services.

## PRESCRIPTION ORDER STATUS

WellDyneRx provides email alerts to track the status of your prescription orders. Select “email” for your contact preference to receive specific order information, refill reminders, and shipment notification, including the estimated delivery date of your order. We offer automated phone messages for select order statuses and refill reminders.

## MEMBER SERVICES

Member Services representatives are available 24 hours a day, 7 days a week to answer questions and help with prescription orders.

**By Phone:** 1-888-479-2000  
1-800-900-6570 TTY

**By Email:** [MemberServices@welldynernx.com](mailto:MemberServices@welldynernx.com)  
Please allow one business day for a response to your email.

Pharmacists are available for consultations 24 hours a day, 7 days a week if you have questions about your medication, including how to take it, what to do if you miss a dose, side effects or drug interactions. For medical emergencies, please call 911.

**By Phone:** 1-888-479-2000  
1-800-900-6570 TTY

**By Email:** [pharmacist@welldynernx.com](mailto:pharmacist@welldynernx.com)  
Please allow one business day for a response to your email.



# Prescription Delivery Service Enrollment Form

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

## INSURANCE CARDHOLDER INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Mid Int \_\_\_\_\_ 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) \_\_\_\_\_  
**Contact Preference:**  Email  Automated Phone Message

Group Name (Primary) \_\_\_\_\_ Group Name (Secondary) \_\_\_\_\_  
 Group ID# \_\_\_\_\_ Member ID# \_\_\_\_\_ Group ID# \_\_\_\_\_ Member ID# \_\_\_\_\_

## ALLERGIES AND HEALTH CONDITIONS

For your safety, WellDyneRx 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

First & Last Name		First & Last Name	
		Relationship to Cardholder	
Date of Birth	<input type="radio"/> Male <input type="radio"/> Female	Date of Birth	<input type="radio"/> Male <input type="radio"/> Female
<b>Drug Allergies</b>	<b>Health Conditions</b>	<b>Drug Allergies</b>	<b>Health Conditions</b>
<input type="radio"/> No Known	<input type="radio"/> No Known	<input type="radio"/> No Known	<input type="radio"/> No Known
<input type="radio"/> Amoxicillin	<input type="radio"/> Asthma	<input type="radio"/> Amoxicillin	<input type="radio"/> Asthma
<input type="radio"/> Aspirin	<input type="radio"/> Bleeding Disorder	<input type="radio"/> Aspirin	<input type="radio"/> Bleeding Disorder
<input type="radio"/> Cephalosporins	<input type="radio"/> COPD	<input type="radio"/> Cephalosporins	<input type="radio"/> COPD
<input type="radio"/> Codeine	<input type="radio"/> Depression	<input type="radio"/> Codeine	<input type="radio"/> Depression
<input type="radio"/> Erythromycin	<input type="radio"/> Diabetes	<input type="radio"/> Erythromycin	<input type="radio"/> Diabetes
<input type="radio"/> Penicillin	<input type="radio"/> GERD/Ulcer	<input type="radio"/> Penicillin	<input type="radio"/> GERD/Ulcer
<input type="radio"/> Sulfa	<input type="radio"/> Heart Disease	<input type="radio"/> Sulfa	<input type="radio"/> Heart Disease
<input type="radio"/> Tetracyclines	<input type="radio"/> High Cholesterol	<input type="radio"/> Tetracyclines	<input type="radio"/> High Cholesterol
<input type="radio"/> Other (Use space below)*	<input type="radio"/> Hypertension	<input type="radio"/> Other (Use space below)*	<input type="radio"/> Hypertension
	<input type="radio"/> Liver Disease		<input type="radio"/> Liver Disease
	<input type="radio"/> Renal Disease		<input type="radio"/> Renal Disease

\*Please Specify Patient and Other Drug Allergies

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**Medication Preference:** WellDyneRx 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, WellDyneRx 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 \_\_\_\_\_