Oregon HEALTH PLAN

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

Medicaid Prime ID number _____

OHP Benefit (choose one):

☐ OHP Standard ☐ OHP Plus

OHP customers: *Put your recipient number (found in field 11 on your OMAP Medical Care ID) in the field marked Medicaid Prime ID number. Your benefit package is found in field 9b on your OMAP Medical Care ID.*

Payment Information

☐ Check enclosed ☐ Credit card ☐ Money Order

☐ DISCOVER ☐ VISA ☐ MasterCard ☐

Credit card number _____

Expiration date _____

Name on card _____

Signature of cardholder _____

Generic Preference

See reverse side for our generic policy.

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 _____

Prescription Items (new, refill & transfer)

	(**For transfers**) Pharmacy Name & Phone number	Prescriber Name & Phone number	Rx #	Medication Name & Strength	Qty.	Price/ Copay
1						
2						
3						
4						

Non-Prescription Items

Item #	Item Description	Qty.	Price Each	Total Price
	Shipping Charge (see reverse for shipping charge information):			
	TOTAL AMOUNT OF ORDER:			

Please complete this form and return it to the address below.
Be sure to enclose your original prescription(s) along with your check, money order or charge information.

ⓜ **Wellpartner, P.O. Box 5909, Portland, OR 97228-5909**
ⓟ 1-877-WELLRXS (1-877-935-5797) toll-free or 503-450-0606 (in Portland) ⓦ www.wellpartner.com

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