Maintenance Medication
Mail Order Request Form

Patient Information

Last Name: _____

First Name: _____

Date of Birth: _____

Address: _____

_____

_____

Phone: _____

Member Identification # (from ID card)

_____

Relationship to card holder: _____

Credit Card for Co-pays (or call (717) 339-2600 with payment information):

__ Visa __ Mastercard __ Discover

Card #: _____

Expiration Date: ____/____ CVV Code: _____

Prescriber Information

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Please have your prescriber send prescriptions to WellSpan Pharmacy in Gettysburg PA:

WellSpan Pharmacy – Adams Health Center
40 V-Twin Drive, Suite 107
Gettysburg, PA 17325

Phone: (717) 339-2600

Fax: (717) 339-2601

Electronic prescriptions accepted

Medications/Allergies

Medications requested:

_____

_____

_____

Allergies: _____

_____

Refill options (please select one):

NOTE: If a refill option isn't selected, the prescription will be entered as an auto refill.

☐ **Auto Refill** Any medications due for refill will be automatically filled, charged and sent to your home (note: this will include **all** prescriptions due for refill).

☐ **Do Not Auto Refill** You will need to contact the pharmacy for future fills of your prescriptions

Please send this completed form via Fax to 717-339-2601

Questions about this form—Email: wahcpharmacy@wellspan.org

Updated 10/2022