Specialty Medication Request Form

Patient Information

Last Name: _____

First Name: _____

Date of Birth: _____

Address: _____

_____

_____

Phone: _____

Insurance Information

Member ID #:_____

PCN:_____

BIN:_____

Person Code: _____

Allergies: _____

Credit Card for Co-pays (or call (855) 339-2305 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 Fairfield PA:

Electronically (preferred) – NCPDP #3973282

WellSpan Pharmacy – Fairfield
4910B Fairfield Rd.
Fairfield, PA 17320

Phone: 1-855-339-2305

Fax: (717) 642-6691

Special Requests

☐ I would like to have non-child resistant caps

Medication Name/Dose:_____

New Medication: Yes No

Rx Number (Refill Medication): _____

Phone Notification You will be notified via phone of medications due for refill. Medications will be sent out only with your permission.

Please send this completed form via Fax to 717-642-6691

Updated 10/2022