

Maintenance Medication Mail Order Request Form

Patient Information	Prescriber Information
Last Name:	Name:
First Name:	Address:
Date of Birth:	
Address:	Phone:
	Fax:
Phone:	Please have your prescriber send prescriptions to WellSpan Pharmacy in Gettysburg PA:
Member Identification # (from ID card)	WellSpan Pharmacy – Adams Health Center 40 V-Twin Drive, Suite 107
Relationship to card holder:	Gettysburg, PA 17325
Credit Card for Co-pays (or call (717) 339-2600	Phone: (717) 339-2600
with payment information):	Fax: (717) 339-2601
Visa Mastercard Discover	Electronic prescriptions accepted
Card #:	
Expiration Date:/ CVV Code:	
Medications/Allergies	
Medications requested:	
Allergies:	
D.Cu., C., (.l.,,)	
Refill options (please select one):	
NOTE: If a refill option isn't selected, the prescription will be entered as an 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	