



Maintenance Medication | Mail Order Request Form

Patient Information

First Name: _____

Last Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Member Identification # (from ID card):

Relationship to card holder: _____

Payment for Co-pays

Credit Card can be provided by calling
(717) 339-2600 or through your MyWellSpan
portal.

Once your prescriptions are on file with
WellSpan Pharmacy, your medications can be
managed at your convenience through the
MyWellSpan portal:

MyWellSpan—2 ways to enroll:

1. Online: www.MyWellSpan.org
2. Phone: 1-866-638-1842

On most medications, members can receive up
to a 100-day supply.

To ensure a smoother transition, please have
your prescriber send your prescriptions

electronically to:

WellSpan Pharmacy – Adams Health Center

40 V Twin Drive, Suite 107

Gettysburg, PA 17325

Phone: (717) 339-2600

Fax: (717) 339-2601

Please list any allergies:

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 by mail
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 call to enroll or email completed form to:

wahcpharmacy@wellspan.org

To protect your privacy, please include "secure" in subject line.