

**Winston-Salem** HEALTH CARE  
**Pharmacy**  
**Mail Order Form**

**Phone:** 336-718-1044 **Toll Free:** 1-888-718-9044

**Fax:** 336-718-1495 **Email:** info@scriptrax.com

Winston Salem Health Care Mail Order Pharmacy

PO Box 24039 Winston Salem, NC 27114-4039

**INSTRUCTIONS FOR ORDERING MAIL ORDER PRESCRIPTIONS**

Welcome to the Winston Salem Health Care Mail Order Pharmacy. The mail order program is perfect for patients that require medication on a recurring basis. Your medications will be mailed directly to your home, making it convenient for you. **A new form must be filled out for each patient using Winston Salem Health Care Mail Order Pharmacy. Please provide your signature where required to authorize.**

**Step 1 – Obtain 90-day Prescription**

First, you must obtain a written prescription from your doctor for up to a **90-day supply with 3 refills**. Please have your doctor verify if your particular medication qualifies for a 90-day prescription as only certain drugs are available for a 90-day supply. You may mail this prescription along with your Mail Order Form or have your physician fax the prescription to 336-718-1551.

**Step 2 – Fill out Mail Order Form**

Completely fill out the form on the back of this page and sign where appropriate. Please print clearly and fill out all required sections of the mail order form. Failure to completely fill out the form delays the processing of your order. **Remember: use one mail order form for each patient ordering medication(s).** Please send this form to Winston Salem Health Care Mail Order Pharmacy in the enclosed return envelope.

**Step 3 – Select Payment Option**

If paying by credit card, make sure to include your credit card number and expiration date. Your order will not be processed or shipped without payment in full. Standard shipping for mail order prescriptions is free. Additional costs will apply if you request expedited shipping.

**Step 4 – Submit form to Winston Salem Health Care Mail Order Pharmacy**

Mail a copy of your completed form and prescription(s) to: Winston Salem Health Care Mail Order Pharmacy, PO Box 24039, Winston-Salem, NC 27114-4039

**Step 5 – Refills**

Refills can be obtained in three ways. Visit [www.scriptrax.com](http://www.scriptrax.com) and click on the "Online Refill" link and follow the simple instructions provided. This secure service is available 24 hours a day, 7 days a week. Call Winston Salem Health Care Mail Order Pharmacy at 1-888-718-9044, or mail your refill request to Winston Salem Health Care Mail Order Pharmacy, PO Box 24039, Winston-Salem, NC 27114-4039.

**Medication Supply Considerations**

To maximize your savings, have your doctor write a prescription for a 90-day supply with 3 refills. If you need a prescription filled before you receive your 90-day supply from the Winston Salem Health Care Mail Order Pharmacy, ask your doctor to write an additional 30-day prescription that you can have filled at your local pharmacy while your Winston Salem Health Care Mail Order Pharmacy order is processed. **Please note: Prescriptions will be filled as written by your doctor. For example: if the prescription specifies a 30-day supply rather than 90-day supply, Winston Salem Health Care Mail Order Pharmacy can only fill the prescription for a 30-day supply.**

Winston Salem Health Care Mail Order Pharmacy regulations prohibit patient requests to return or cancel prescription orders after the order has been shipped and received by the patient.





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**1 – Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth (mm / dd / yyyy) \_\_\_\_\_ Patient Relation to Member \_\_\_\_\_ Gender (circle one)  
I = Insured S = Spouse D = Dependent  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Male Female

**2 – Shipping Address**

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

**3 – Drug Allergies**

Yes / No If yes, please list (attach additional pages if necessary)

**4 – Member ID Card Information**

Cardholder Last Name (if different from patient) \_\_\_\_\_ MI \_\_\_\_\_ First Name \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

**5 – Payment Information**

Credit Card: (Circle one) MasterCard Visa Credit Card # \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_ (signature authorizes charge to my credit card)

**6 – Prescription Information**

Medication Name, Strength, Quantity	Doctor's Name	Doctor's Phone Number	Refill Rx Number
1.			
2.			
3.			

**7 – Patient Authorization**

By signing below, I certify that the information on this form is correct, and I authorize release of information regarding my medical and prescription drug history to Winston Salem Health Care Mail Order Pharmacy.

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Signature: \_\_\_\_\_

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