

Walmart Home Delivery
1025 West Trinity Mills Rd
Carrollton, TX 75006



PH: 1-800-273-3455
Fax: 1-800-406-8976

wmsrx@wal-mart.com

Prescription Order Form

Please complete a separate form for each family member enrolling in the mail order service. Your order may be delayed if any information is missing or incomplete. Please mail this form to the address listed above.

Privacy Notice: We cannot discuss health information about any patient with anyone other than the patient, the patient's parents or legal guardians (for minors), or individuals with medical power of attorney or listed on the Designation Form for the patient.

Patient Information

Name (Last, First, Middle):

City: State: ZIP:

Home Phone: Alternate Phone (if applicable):

Date of Birth: Male: Female: Email Address:

Allergies (drug, other):

Health Conditions:

Current Medications:

Insurance or Prescription Plan Information (Only required if you are new to the Home Delivery or if your information has changed since your last order. If you are Medicare or Medicaid eligible, call 1-800-273-3455 to set up your profile.)

I am a new customer My information has changed I am a Self Pay customer

Insurance ID #: Group#: Employer (if applicable):

Name of Insured/Policy Holder (Last, First, Middle):

Relationship to Insured/Policy Holder:

Prefers Brand Drugs*: Yes No

*Your co-pays may be significantly affected if you select Yes.

Healthcare Provider Information (Please provide information on the physician you see most often.)

Physician Name: Phone:

Payment Information

To help insure the security and privacy of your financial data, we do not request credit card information by fax or mail. To pay for your order, please allow us time to process this form (3-5 days if mailing this form, 1-2 days for faxes) and then call us at 1-800-273-3455 with your payment information.

Prescription Details

Refill New Prescription Transfer Pharmacy Name: Phone:

For refills, please only enter Rx numbers from current prescription labels. For new prescriptions and transfers, please enter the medication name, quantity and strength.

1. <input type="text"/>	4. <input type="text"/>
2. <input type="text"/>	5. <input type="text"/>
3. <input type="text"/>	6. <input type="text"/>

Signature: Date: