



CareOregon

Please complete this form and return it to Wellpartner, P.O. Box 5909, Portland, OR 97228-5909. Be sure to enclose your original prescription(s).

Patient Information

Last Name _____
First Name _____ MI _____
Date of Birth _____ Male Female
Primary Provider _____
Provider Phone # _____
Medical Record # (if applicable) _____

CareOregon ID number _____

OHP customers: Put your recipient number (found in field 11 on your OMAP Medical Care ID) in the field marked Medicaid Prime ID number. Your benefit package is found in field 9b on your OMAP Medical Care ID.

Allergies (Check all that apply)

- None known Aspirin Codeine
Erythromycin Penicillin Morphine Sulfa
Other _____

Medical Conditions (Check all that apply)

- None known Active Ulcer Arthritis Asthma
Congestive Heart Failure Diabetes
High Blood Pressure Hyperthyroid Hypothyroid
Kidney Disorder Liver Disorder
Other _____

Shipping Information

- Permanent address Address for this order only

Address _____
City _____ State _____ Zip _____
Daytime Phone _____
E-mail Address _____

Safety Cap Preference

Federal Law requires us to dispense your medication with a child-resistant cap. If you do NOT want to receive your medications with child-resistant caps, please sign below.

Signed _____

Prescription Items (new, refill & transfer)

Table with 5 columns: Pharmacy Name & Phone number, Provider Name & Phone number, Rx #, Medication Name & Strength, Qty. Rows 1-7.



Wellpartner
Your Personal Pharmacy