Walmart Home Delivery
P.O. Box 115112
Carrollton, TX 75011-5112

PH: 1-800-273-3455
Fax: 1-800-406-8976
www.walmart.com/homedelivery
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.

Patient Information

Name (Last, First, Middle):

Address:

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

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):

Insurance/Plan Name: BIN #: PCN #:

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

Relationship to Insured/Policy Holder: Insurance/Plan Ph #:

Prefers Brand Drugs:* ☐ Yes ☐ No

*Your copays may be significantly affected if you select Yes.

Health care Provider Information

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

Physician Name: Phone:

Payment Information

To help ensure 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, and then call us at 1-800-273-3455 with your payment information. You may also enroll in the Rx Express Pay Program if you set up your account online at www.walmart.com/homedelivery.

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. 4.
2. 5.
3. 6.

Signature: Date: