Walmart Home Delivery
1025 W Trinity Mills Rd.
Carrollton, TX 75006

Capital RX Member:
PH: 1-800-236-7563
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.

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

❒ I am a new customer ❒ My information has changed

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 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 and then call us at 1-800-236-7563 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.
2.
3.
4.
5.
6.

Signature: Date: