



**House of Wellness Pharmacy**

S2845 White Eagle Road  
Baraboo, WI 53913

Ph: 608-355-5177 Fax: 608-356-1233

**Health Care Center Pharmacy**

N6520 Lumberjack Guy Road  
Black River Falls, WI 54615

Ph: 888-685-4422 ext 5312 Fax: 715-284-2293



# TRANSFER MY PRESCRIPTIONS

PLEASE COMPLETE ONE FORM FOR EACH FAMILY MEMBER

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Tribal member  Yes  No

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Text message notification when Rx is ready  Yes  No

Allergies: \_\_\_\_\_ Ho-Chunk Employee  Yes  No

Insurance Cardholder ID # (SSN for Auxiant) \_\_\_\_\_

**CURRENT PHARMACY INFORMATION (If you have more than one pharmacy, please list)**

1. Pharmacy name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy address: \_\_\_\_\_

2. Pharmacy name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy address: \_\_\_\_\_

**Medications you would like to transfer (Rx#s are NOT required to submit form ): Fill now?**

- |          |            |                      |                          |
|----------|------------|----------------------|--------------------------|
| 1. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |
| 2. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |
| 3. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |
| 4. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |
| 5. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |
| 6. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |
| 7. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |
| 8. _____ | RX # _____ | Pharmacy name: _____ | <input type="checkbox"/> |

How would you like to obtain your prescriptions?

- Pick up at House of Wellness Pharmacy in Baraboo
- Pick up at Heath Care Center Pharmacy in Black River Falls
- Mail (if you are a non-tribal member, please contact the pharmacy to provide credit card information for co-pays)

**Please drop off, fax, or mail this form to us**