# Account Setup Form

Fax to: 561-223-3885 or email to: newaccount@wellsrx.com

Thank you for selecting Wells Pharmacy Network for your compounding needs.
Your Wells Pharmacy Account Team is available to answer any questions you may have about the application.
We look forward to serving you and your patients.

## Office Information

Prescriber* Name _____ ▶ Signature _____

DEA# (required) _____ State License # _____

Practice/Clinic Name _____ NPI # _____

Is this the Primary Location? ☐ (You must indicate which location is the prescriber's primary location.)

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Office Contact if Other Than Prescriber _____ Phone _____

Website _____

**Shipping Tracking Information**

Email _____

**Other Locations**

_____

_____

**Credit Card**

Type _____ Number _____

Exp _____ CW _____ ZIP _____

**Signature Required (must be a wet signature)**

Prescribers Signature _____ DEA Number _____
(DEA License holder of ordering controlled substance)

_____
Please print Prescriber's Name

**Please Note:** Anytime you have a change to an Authorized Agent you will need to resubmit this form. List all.