

Reimbursement Claim Form



Instructions

1. Fill out all of the information on the claim form as completely as possible.
2. Please complete a separate claim form for each family member.
3. Please include the original pharmacy label with prescription details from your pharmacy when submitting the WellDyne Claim Form. Cash register tape, photocopies and hand written information will not be accepted.
4. If necessary, contact the pharmacist to request a copy of the pharmacy label which includes the detailed drug information requested on the form for the prescription(s) dispensed.
5. Please provide the complete name, address and telephone number of the pharmacy. Should you or the pharmacist have questions regarding the completion of this form, please call our toll-free number at 888-479-2000. You can reach us 24 hours a day, 7 days a week.
6. If this is a compound claim, please request a Universal Compound Claim Form from your pharmacy with all NDC numbers used in the compound. A minimum of two NDC numbers should be provided.
7. Mail the completed form and original receipts directly to: **WellDyne, PO BOX 90369, LAKE LAND, FL 33804**
8. Claims are processed within 30 business days from date received.

Use this form to be reimbursed for each prescription that you purchased without your prescription card.

You will be reimbursed the network pharmacy rates, minus co-pays.

Employee Information

Employer's Name _____ Group Number _____

Last Name _____ First Name _____ Mid Initial _____

Cardholder ID# _____

Address _____

City _____ State _____ Zip _____

Daytime Phone Number _____ Email Address _____

Patient Information

Patient's Last Name _____ First Name _____ Mid Initial _____

/ /

Birthdate (mm/dd/year) _____

Male _____ Female _____

Patient's relationship to employee:

Self _____ Spouse _____ Child _____ Other _____

Prescription #1 Information

Rx Number _____ Date Filled _____

Quantity _____ Day Supply _____ Amount Paid _____

Prescribing Doctor DEA Number or Name _____

Medication Name and Strength (mg., ml., etc.) _____

NDC Number _____

Is this Drug: (Check All That Apply)

New Prescription _____ Refill _____
Compound Rx _____ Allergy Injectable _____

Prescription #2 Information

Rx Number _____ Date Filled _____

Quantity _____ Day Supply _____ Amount Paid _____

Prescribing Doctor DEA Number or Name _____

Medication Name and Strength (mg., ml., etc.) _____

NDC Number _____

Is this Drug: (Check All That Apply)

New Prescription _____ Refill _____
Compound Rx _____ Allergy Injectable _____

Reimbursement Claim Form



Prescription #3 Information

Rx Number _____ Date Filled _____

Quantity _____ Day Supply _____ Amount Paid _____

Prescribing Doctor DEA Number or Name _____

Medication Name and Strength (mg., ml., etc.) _____

NDC Number _____

Is this Drug: (Check All That Apply)

New Prescription Refill
Compound Rx Allergy Injectable

Prescription #4 Information

Rx Number _____ Date Filled _____

Quantity _____ Day Supply _____ Amount Paid _____

Prescribing Doctor DEA Number or Name _____

Medication Name and Strength (mg., ml., etc.) _____

NDC Number _____

Is this Drug: (Check All That Apply)

New Prescription Refill
Compound Rx Allergy Injectable

Prescription #5 Information

Rx Number _____ Date Filled _____

Quantity _____ Day Supply _____ Amount Paid _____

Prescribing Doctor DEA Number or Name _____

Medication Name and Strength (mg., ml., etc.) _____

NDC Number _____

Is this Drug: (Check All That Apply)

New Prescription Refill
Compound Rx Allergy Injectable

Prescription #6 Information

Rx Number _____ Date Filled _____

Quantity _____ Day Supply _____ Amount Paid _____

Prescribing Doctor DEA Number or Name _____

Medication Name and Strength (mg., ml., etc.) _____

NDC Number _____

Is this Drug: (Check All That Apply)

New Prescription Refill
Compound Rx Allergy Injectable

Pharmacy Name _____ Address _____ City _____ State _____ Zip Code _____

Phone Number _____ NPI Number _____

I certify that the information on this claim form is correct and authorize release of all information to WellDyneRx and the Plan Sponsor. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan. I verify that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.

This form must be signed:

Employee/Member's Signature _____

Date _____