Prescription Reimbursement Claim Form

Reimbursement will only be provided for in-network pharmacy services

Use this form to be reimbursed for each prescription that you purchased without your prescription card at in-network pharmacies only. You will be reimbursed the pharmacy rates, minus co-payments.

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 receipt with prescription details from your pharmacy. Cash register tape and photocopies will not be accepted.
4. If necessary, contact the pharmacist to provide 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.
6. Mail the completed form and original receipts directly to:
   WellDyneRx Claim Reimbursement
   PO Box 90369
   Lakeland, FL 33804
7. You will receive a response within 30 days.

EMPLOYEE INFORMATION		
Rx Group ID#	Rx Member ID#	
Last Name	First Name	Middle Initial
Address 1		
Address 2		
City	State	Zip Code
Daytime Phone Number	Email Address	

PATIENT INFORMATION		
Patient's Last Name	First Name	Middle Initial
Birthdate (m/d/y): _____/ _____/ _____		
☐ Male ☐ Female		
Patient's Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other		

PRESCRIPTION #1		
Rx Number	Date Filled	
Quantity	Days 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		
Rx Number	Date Filled	
Quantity	Days 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 #3		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ☐ New Prescription ☐ Refill ☐ Compound Rx ☐ Allergy Injectable		

PRESCRIPTION #4		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ☐ New Prescription ☐ Refill ☐ Compound Rx ☐ Allergy Injectable		

PRESCRIPTION #5		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ☐ New Prescription ☐ Refill ☐ Compound Rx ☐ Allergy Injectable		

PRESCRIPTION #6		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ☐ New Prescription ☐ Refill ☐ Compound Rx ☐ Allergy Injectable		

Pharmacy Name Address City State Zip Code

Pharmacy Telephone 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