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. 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.
4. Please include the original pharmacy label with prescription details from your pharmacy when submitting this form. Cash register receipt, photocopies and hand written information will not be accepted. **Examples can be found below.**
5. If necessary, contact the pharmacist to request a copy of the pharmacy label for each prescription you are requesting reimbursement..
6. 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 the phone number located on your Member ID card. You can reach us 24 hours a day, 7 days a week.
7. Mail the following documents directly to: **WellDyne Claims Department, PO Box 90369, Lakeland, FL 33804**
   - Completed reimbursement claim form
   - Original pharmacy label (Example below)
   - Original pharmacy receipt (Example below)
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.

Patient Information

Patient's Last Name

First Name

/ /

Birthdate (mm/dd/year)

Cardholder ID#

Include the original pharmacy label/receipt with prescription details

Pharmacy Receipt Example

Pharmacy Name
Pharmacy Address
and Phone Number

Date

Rx Item 1 $Price
Rx Item 2 $Price
Rx Item 3 $Price

$Total Price
Payment Method

Pharmacy Label Example

Pharmacy Name

Pharmacy Address
and Phone Number

Rx #000000000000

Date Filled

Patient Name
Patient Address

Medication Name
Quantity

NDC #
Day Supply

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:

Patient/Cardholder Signature/Member's Signature

Date