# 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, LAKELAND, 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 | Days Suppy | 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 | Days Suppy | 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

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## Prescription #3 Information

Rx Number | Date Filled

Quantity | Days Suppy | 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 | Days Suppy | 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 | Days Suppy | 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 | Days Suppy | 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