Prescription Drug Claim Form

Important: Pleas 1. Policyholder o			•	•	•							
•			-		-							
		Ctata				Zip Code						
		Zip Gode										
3. Why was your					· ·							
4. Employer Nam												
5. Patient's Name6. Patient's Birth	•	•				. □ M □ F						
8. Patient's Relat												
□Self (Male) □				□Wif	e □So	on 🗆 Daugh	nter [Other Male		Other Fen Depender	nale nt	
9. Is the patient	eligible	for a	ny other Pre	scription	Drug Cover	age? 🗌 Yes 🗀	□ No If \	'es, you mus	t comp	lete the f	ollowing:	
Does the other		•		•		J	r Medic	al				
								Effective Date				
Spouse's Birth Date// Insured's ID Number Effective Date MM DD YY Insurance Company Name												
Insurance Con Address (Stree												
I certify that the	•		•								of any	
medical informat	•		_			_	•				·	
Signature												
	ne info	rmatio	n below or a	attach the	original re	ceipt to this fo		photocopies		accepted		
Rx Number	Date Fi	illed	Check One	Metric Quantity	Days Supply	MD Name		Is Rx No DAW MD DAW	□ 0 □ 1	Rx Price (including	tax)	
1.			☐ New Rx ☐ Refill Rx			Prescriber ID No	0.	Patient DAW RPh DAW	□ 2 □ 3	•		
		Medic	cation Name, Strength		Is Drug	NDC Number		No Generic	<u> </u>	\$		
Dosa		Dosag	ge Form		Compound Rx 🗌					D D:		
Rx Number	Date Filled		Check One	Metric Quantity	Days Supply	MD Name		Is Rx No DAW MD DAW	□ 0 □ 1	Rx Price (including	tax)	
2.			☐ New Rx ☐ Refill Rx			Prescriber ID No.		Patient DAW RPh DAW	□ 2 □ 3			
Reference Number	<u> </u> .	Medic	ation Name, St	renath	Is Drug	NDC Number		No Generic	<u> </u>	\$		
Dosa		Dosag	ge Form		Compound Rx 🗆	npound						
Rx Number	Date Filled		Check One	Metric Quantity	Days Supply	MD Name		Is Rx No DAW MD DAW	□ 0 □ 1	Rx Price (including		
			☐ New Rx			Prescriber ID No	0.	Patient DAW	□ 2			
3.			☐ Refill Rx					RPh DAW No Generic	□ 3 □ 4	\$		
Reference Number Medi Dosa		Medica Dosage	cation Name, Strength ge Form		Is Drug Compound Rx	NDC Number						
If more than thr	ree pre	script	ions, please	fill out a	dditional c	laim forms.	. ,		•			
Pharmacy Name			Phone I	Vo.		Street		City	Sta	te	Zip	
Pharmacist Must Complete							Note: Pay	ment for the above er. Any assignmen	claim(s) v	vill be made d	lirectly to the	
								of the Policyholder				
Provider ID No. A-4070o 0606			Pharmacist Signature Please return completed form to the address shown on reverse side.									

Instructions

Policyholder:

- 1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims that were purchased without using your drug card, or due to an emergency situation.
- 2. You will be reimbursed directly for all covered services up to the allowed amount.
- 3. Complete all items in the top section for both the patient and policyholder.
- 4. Sign the form in the area provided.
- 5. Be sure to include the original cash receipt with this form, and make copies for your own records.
- 6. Have your pharmacist complete the bottom section of the form.
- 7. For a list of participating pharmacies in your area, please refer to your member kit materials or call your customer service area.
- 8. Mail completed form to WellPoint NextRx, P.O. Box 145433, Cincinnati, OH 45250-5433.

Pharmacist:

- 1. Complete all items in the lower portion of this form.
- 2. Use a separate form for each patient.
- 3. Be sure to sign the form in the area provided.

If you have any questions, please call your Customer Service area.

Insurance Fraud Warning

It is unlawful to knowingly provide, false incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.

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