Prescription Reimbursement Claim Form

Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Part 1 Cardholder/ Member Information

Part 1 must be fully completed to ensure proper reimbursement of your claim.

Please type or print clearly.

Cardholder ID No.

Cardholder Name Address

City State Zip

Member Information - Use a separate claim form for each family member

Member Name Date of Birth _____/_____/_____

Member: ☐ Male ☐ Female Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Are any of these medicines being taken for an on-the-job injury: ☐ Yes ☐ No

Is the medicine covered under any other group insurance? ☐ Yes ☐ No

If yes, is other coverage: ☐ Primary ☐ Secondary If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurer Policy # ID # Phone ( )

I certify that I (or my eligible dependent) have received the medicine described herein and that the member named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of any on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to CVS/Caremark, the plan administrator, insurance underwriter, plan sponsor, policyholder and/or employer. I certify that all the information entered on this form is correct.

x _____ _____/_____/_____

Signature of Cardholder or Legal Representative **Date**

Part 2 Important!

Please remember to include all original pharmacy receipts.

Please note all of the following information needs to be either on your pharmacy receipt or included on this claim form for reimbursement:

- Date Purchased
- Foreign Country Where Medicine Purchased
- Foreign Currency Type
- Medicine Name
- Medicine Strength / or NDC Number
- Member Name
- Metric Quantity, Days Supply
- Pharmacy Name and Address or NABP Number
- Physician NPI Number*
- Physician First and Last Name*
- Physician Full Address*
- Prescription Number
- Total Charge

*The pharmacy should be able to provide this information to you or you may obtain it by contacting your physicians office. This is needed for every claim.

Part 3 Pharmacy Information

Pharmacist to complete this section ONLY if original pharmacy receipts are not included.

- To ensure that the member receives accurate and timely reimbursement for medical purchases, please assist in completing the information below.
- If compound prescription, please enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescriptions sections on the reverse side.

Pharmacy Name Pharmacy NABP No.

Pharmacy Address City

State Zip Phone ( )

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefits payments as related to the charges listed below will be paid directly to the cardholder.

x _____ ___/___/___

Signature of Pharmacist of Representative **Date**

(Required only if original pharmacy receipts are not included)

Rx 1	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	☐ New ☐ Refill ☐ DAW ☐ Compound			For office use only Prior Approval Code
	NDC #		Medicine Name and Strength		Metric Quantity	Days Supply	Total Charges
Rx 2	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	☐ New ☐ Refill ☐ DAW ☐ Compound			For office use only Prior Approval Code
	NDC #		Medicine Name and Strength		Metric Quantity	Days Supply	Total Charges

Rx 3								
	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	☐ New ☐ Refill ☐ DAW ☐ Compound			For office use only Prior Approval Code
	NDC #		Medicine Name and Strength		Metric Quantity	Days Supply	Total Charges

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

HOW TO COMPLETE THIS FORM

Cardholder / Member Information

Complete all cardholder and member information in Part 1 on the reverse side.

- The Cardholder ID number can be found on your ID Card.
- Sign and Date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you mail. No documents will be returned.

CLAIM SUBMISSION

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each member
- Each pharmacy from which you purchase

File as soon as possible after the date of service.

Your claim must be filed by the timely filing deadline. Please refer to your coverage document for the specific timely filing guideline.

DO NOT include charges for durable medical equipment that required a prescription to obtain. Please submit durable medical equipment on the Member Claim Form.

DO NOT submit cancelled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

PHARMACY INFORMATION

If a compound prescription, enter the NDC number of the most expensive ingredient of the legend medicine use.

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC #	Prescription Ingredient	Quantity	Charge

MAIL THIS FORM TO:

CVS/Caremark
Claims
PO Box 52136
Phoenix, AZ 85072-2136

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي : 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တ၀်ဒုးသ့ဉ်ညါ–နမ့်ကတိၤကညီကျိာ်.ကျိာ်တ်မၤစၤတ်ဖံးတ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.အိဉ်လၢနဂီၢ်လီၤ. ဆဲးကျိးဆူ၀၀–၅၂၄–၉၂၄၂မ့တမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ာ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 መደም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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