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WellDyneRx Prescription Drug 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. Provide an original receipt with prescription details from your pharmacy. Cash register tape and photo copies 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. Should you or the pharmacist have questions regarding the completion of this form, please call our toll-free number **888-479-2000**. You can reach us between the hours of 7:00 a.m. and 7:00 p.m. (MST), Monday through Friday and 8:00 a.m. to 12:00 p.m. (MST) Saturday.
6. Mail the completed form and original receipts directly to:

   WellDyneRx
   PO Box 4517
   Englewood, CO 80155
7. You will receive a response within 30 days.

Use this form to be reimbursed for each prescription that you purchased without your prescription card. You will be reimbursed network pharmacy rates, less co-pays.

EMPLOYEE INFORMATION

Employer's Name | Group Number

Last Name | First Name | Middle Initial

Cardholder ID#

Address

City, State, Zip Code

Daytime Phone Number
(_____)_____

PATIENT INFORMATION

Patient's Last Name | First Name | Middle Initial

Birthdate (mo/day/yr) _____ / _____ / _____

Male ◯ Female ◯

Patient's Relationship to Employee:
Self ◯ Spouse ◯ Child ◯ Other ◯

PRESCRIPTION #1 INFORMATION

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 #2 INFORMATION

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 #3 INFORMATION

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 INFORMATION

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 INFORMATION

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 INFORMATION

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

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