

WellDyneRx 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 receipt with prescription details from your pharmacy when submitting the WellDyneRx Claim Form. Cash register tape and photocopies 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 at 888-479-2000 You can reach us 24 hours a day, 7 days a week.
- 6. Mail the completed form and original receipts directly to:

WELLDYNERX PO BOX 90369 LAKELAND, FL 33804

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 the network pharmacy rates, minus co-pays.

EMPLOYEE INFO	RMATION		PATIENT INFORMATION						
Employer's Name		Group Nu	mber	Patient's Last Nar	ne Fi	rst Name		Middle Initial	
Last Name	First N	ame	Middle Initial	Birthdate (m/d/y)://					
Cardholder ID#				Male □	Femal	Female □			
Address									
0''		100	Patient's Relationship to Employee						
City		State	Zip Code	Self □ S	Self □ Spouse □			Other 🗖	
Daytime Phone N	umber	Email Addre	ess			5	- -	5.	
DDECODIDEION	"4 INECOM	TION		DDECODIDEION	"0 INITODI	ATION			
PRESCRIPTION #1 INFORMATION				PRESCRIPTION #2 INFORMATION Rx Number Date Filled					
Rx Number D		Pate Filled		Rx Number		Date Filled			
Quantity	Days Supp	ly	Amount Paid	Quantity	Days Supp	Days Supply Amount Paid		Paid	
Prescribing Doctor DEA Number or Name				Prescribing Doctor DEA Number or Name					
Medication Name and Strength (mg., ml., etc.)				Medication Name and Strength (mg., ml., etc.)					
NDC Number:				NDC Number:					
Is this Drug: (Check All That Apply)				Is this Drug: (Check All That Apply)					
□ New Presc	ription	□ Refill		□ New Prescription □ Refill					
□ Compound Rx □ Allergy Injectable □ Compound Rx □ Allergy Injectable								ole	

PRESCRIPTION #3 INFORMATION					PRESCRIPTION #4 INFORMATION					
Rx Number	Rx Number		Date Filled		Rx Number		Date Filled			
Quantity	Days S	upply	Amount Paid	Qu	antity	Days Su	ipply	Amount Paid		
Prescribing Doctor D	DEA Num	ber or Name		Prescribing Doctor DEA Number or Name						
Medication Name and Strength (mg., ml., etc.)					Medication Name and Strength (mg., ml., etc.)					
g.,, etc.,										
NDC Number:				NDC Number:						
Is the Drug: (Check	All That	Apply)		ls t	Is the Drug: (Check All That Apply)					
□ New Prescriptio	n	☐ Refill			☐ New Prescription ☐ Refill					
					•					
☐ Compound Rx		□ Allergy I	njectable		Compound Rx		□ Aller	gy Injectable		
PRESCRIPTION #5	INFORM	/ATION		PR	ESCRIPTION #	6 INFORI	MATION			
Rx Number		Date Filled			Number	-	Date Filled	t		
Quantity	Days S	upply	Amount Paid	Qu	antity	Days S	upply	Amount Paid		
j		,			,		,			
Prescribing Doctor F	DEA Num	pher or Name		Prescribing Doctor DEA Number or Name						
Prescribing Doctor DEA Number or Name				116	r rescribing boctor bear number of Name					
Madication Name and Changeth (and and ata)				Medication Name and Strength (mg., ml., etc.)						
Medication Name and Strength (mg., ml., etc.)				IVIE	Wiedication Name and Ottength (fig., fil., etc.)					
NIDO Niverbase					NDC Number:					
NDC Number:					NDC Number.					
Is the Drug: (Check All That Apply)					Is the Drug: (Check All That Apply)					
					Naw Dragorinti		D D-6			
□ New Prescriptio	n	☐ Refill			New Prescripti	on	☐ Refi	II		
☐ Compound Rx		Allergy In	jectable		Compound Rx		☐ Allei	rgy Injectable		
Pharmacy Name	,	Address	Cit	./	Sta	ıte.		Zip Code		
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						NE				
Pha	rmacy Te	elephone Num	per			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.										
This form must be signed: Employee/Member's Signature Date										
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