



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

Cardholder ID No. _____

Cardholder Name _____ Address _____

City _____ State _____ Zip _____

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

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

Please type or print clearly.

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

- 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 () _____

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

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.	<input type="checkbox"/> New <input type="checkbox"/> Refill <input type="checkbox"/> DAW <input type="checkbox"/> 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.	<input type="checkbox"/> New <input type="checkbox"/> Refill <input type="checkbox"/> DAW <input type="checkbox"/> 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.	<input type="checkbox"/> New <input type="checkbox"/> Refill <input type="checkbox"/> DAW <input type="checkbox"/> Compound		For office use only	
	NDC #		Medicine Name and Strength	Metric Quantity	Days Supply	Prior Approval Code	

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.

C O M P O U N D P R E S C R I P T I O N S			
For pharmacy use only			
NDC #	Prescription Ingredient	Quantity	Charge

MAIL THIS FORM TO:

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



Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

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).

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

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)。

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 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).

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).

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).

တၢ်ဒုးသုဂ်ညါ-န့ၢ်ကတိၢ်ကေညါကိၣ်, ကိၣ်တၢ်မၤစၢတၢ်ဖဲတၢ်မၤတဖၣ်, လၢတဘၣ်လၢတဘၣ်လၢ, ဆိၣ်လၢန့ၢ်လိၤဆဲးကိၣ်ဆူ ၈၀၀-၅၂၄-၉၂၄ န့ၣ်တဖၣ် (TTY: ၈၈၈-၇၈၁-၄၂၆) တက့ၢ်.

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

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

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।

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ທີ່ຕໍ່ຕິ. (TTY: 888-781-4262.)

ማሰብያ: ከግርግር ለሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶቻችን ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም በ(TTY: 888-781-4262) ደውሎ ያነጋግሩን።

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

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

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)।

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

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).

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'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hółne' 800-524-9242 doodai' (TTY: 888-781-4262)