



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 Address _____

State _____ 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				

Wellmark Language Assistance

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, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 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 (٢٦٢٤-١٨٧-٨٨٨) أو (خدمة الهاتف النصي: ٢٤٢٩-٤٢٥-٠٠٨).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262).

주의: 한국어를 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 Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

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

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

တရားဝင်ပြောဆိုမှုကို ကူညီပေးရန်, ကိုက်ညီသော အသံထုတ်လုပ်မှုများကို, အသံထုတ်လုပ်မှုများကို, အသံထုတ်လုပ်မှုများကို (TTY: 888-781-4262) ဝတ်တရား.

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: ከግርግር ግሚና፣ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም በ(TTY: 888-781-4262) ደውለው ያነጋግሩ።

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).

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

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. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)