

Prescription Reimbursement Claim Form Drug Card (drugs covered under prescription drug benefit)

Wellmark Blue Cross and Blue Shield of Iowa 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 Catalyst RX, 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.

- Member Name
- Pharmacy Name and address or NABP Number
- Prescription Number
- Date Purchased
- Total Charge
- Medicine Strength/or NDC Number
- Medicine Name
- Metric Quantity, Days Supply

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.

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

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 within 365 days from the service date.

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:

Catalyst RX
Claims Department
PO Box 1069
Rockville, MD 20849-1069