



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

Wellmark BlueCross BlueShield of Iowa  
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

**Part 1** Cardholder ID No. \_\_\_\_\_

**Cardholder/Member Information**

Cardholder Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Member Information—Use a separate claim form for each family member

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

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 an 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.

\_\_\_\_\_ / / \_\_\_\_\_  
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.

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 benefit payments as related to the charges listed below will be paid directly to the cardholder.

\_\_\_\_\_ / / \_\_\_\_\_  
Signature of Pharmacist or Representative Date  
(Required only if original pharmacy receipts are not included)

<b>Rx 1</b>	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound	For office use only Prior Approval Code	
	NDC #	Medicine Name and Strength		Metric Quantity	Days Supply	Total Charges

<b>Rx 2</b>	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound	For office use only Prior Approval Code	
	NDC #	Medicine Name and Strength		Metric Quantity	Days Supply	Total Charges

<b>Rx 3</b>	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> 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 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 prescription medicines

DO NOT include charges for durable medical equipment that required a prescription to obtain. No benefits will be provided under this plan for such items.

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 used.

COMPOUND PRESCRIPTIONS <small>For pharmacy use only</small>			
NDC #	Prescription Ingredient	Quantity	Charge

## MAIL THIS FORM TO:

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