

# Medicare Part D Prescription Drug Claim Form



**Important: Please read the instructions (on the reverse side) carefully prior to completing this form.**

## A. - Cardholder / Patient Information:

Cardholder's Last Name	First Name	Middle Initial	Plan Name	Cardholder ID Number	Today's Date
Address			City	State	ZIP
Why was the insurance or drug card NOT used for this purchase? Explain below.					
Employer Name				Group Number	
Patient's Last Name	First Name	Middle Initial	Patient's Date of Birth	Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient's Relationship to Cardholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Dependent					
Is patient eligible for primary Rx coverage from another provider? <input type="checkbox"/> No <input type="checkbox"/> Yes			If Yes, does the coverage include either of the following? <input type="checkbox"/> Major Medical <input type="checkbox"/> Drug <input type="checkbox"/> Other Medical		
If Yes, Please complete the following:					
Insured's Last Name	First Name	Middle Initial	Insurance Company's Name	Insured's ID #	Other Coverage's Effective Date
Other Insurance Company's Address			City	State	ZIP
I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to WellPoint NextRx, its agents or representatives.					
Signature				Date	

## B. - Claim Information (completed by pharmacist). Complete all sections or attach the original receipt. Receipt copies will not be accepted.

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No
Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage
Charge (including tax)	Prescriber Name	Prescriber ID		
Is there more than one prescription to complete? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please record other prescriptions in the space provided on the back of this form.				

## C. - Authorization

Pharmacy Name	Address	City	State	ZIP
Pharmacist Signature			<small>Note: Payment for the above claims(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of WellPoint NextRx.</small>	

Please return completed form to the address shown on the reverse side.

**If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your I.D. card or in your enrollment booklet.**

**Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en folleto de inscripción.**

## INSTRUCTIONS

### Cardholder

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims that were purchased without using your drug card, or due to an emergency.
2. You will be reimbursed directly for all covered services up to the allowed amount.
3. Complete all items in the top section for both the patient and the cardholder.
4. Sign the form in the area provided.
5. Be sure to include the original cash receipt with this form, and make copies for your own records.
6. Have your pharmacist complete the bottom section of the form.
7. For a list of participating pharmacies in your area, please refer to your member kit materials or call your customer service area.
8. Mail completed form to: **WellPoint NextRx - P.O. Box 4496, Woodland Hills, CA 91365-4496.**

### Pharmacist:

1. Complete all items in sections (B) and (C) of the form. Complete section (D) if needed.
2. Use a separate form for each patient.
3. Be sure to sign the form in the area provided.

**If you have any questions, please call your Customer Service area.**

### Insurance Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.

### D. - Additional Prescriptions

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2.</b>				
Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage
Charge (including tax)	Prescriber Name		Prescriber ID	

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number	Is this a Compound Rx? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3.</b>				
Quantity	Days Supplied	National Drug Code (NDC)	Medication Name	Strength/Dosage
Charge (including tax)	Prescriber Name		Prescriber ID	

**If more than three prescriptions, please fill out additional claim forms.**