

Medicare Part D Prescription Drug Claim Form



Important: Please read the instructions sheet carefully prior to completing this form.

A. - Cardholder / Patient Information		Today's Date			
Cardholder's Name (Last, First, MI)		Cardholder ID Number		Plan Name	
Street Address		City		State	ZIP Code
Patient's Name (Last, First, MI)		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 Dependant					
Why was the insurance or drug card NOT used for this purchase? Explain below.					

B. - Other Insurance Coverage

Is the patient eligible for primary prescription drug coverage from another provider? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please use other insurance card to complete the fields below.		
Insured's Name (Last, First, MI)	Other Insurance Member ID #	PCN
Other Insurance Company's Name		Other Coverage's Effective Date

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
_____	_____

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.

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C. - Claim Information
(Completed by pharmacist/physician)

Complete all sections or attach the *original* pharmacy prescription receipt. Receipt copies will not be accepted.

1. Is this a compound Rx? If Yes, please attach a Compound Claim form. <input type="checkbox"/> No <input type="checkbox"/> Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (Including tax)	Prescriber Name	Prescriber ID	
2. Is this a compound Rx? If Yes, please attach a Compound Claim form. <input type="checkbox"/> No <input type="checkbox"/> Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (Including tax)	Prescriber Name	Prescriber ID	
3. Is this a compound Rx? If Yes, please attach a Compound Claim form. <input type="checkbox"/> No <input type="checkbox"/> Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (Including tax)	Prescriber Name	Prescriber ID	
4. Is this a compound Rx? If Yes, please attach a Compound Claim form. <input type="checkbox"/> No <input type="checkbox"/> Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (Including tax)	Prescriber Name	Prescriber ID	
5. Is this a compound Rx? If Yes, please attach a Compound Claim form. <input type="checkbox"/> No <input type="checkbox"/> Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (Including tax)	Prescriber Name	Prescriber ID	
6. Is this a compound Rx? If Yes, please attach a Compound Claim form. <input type="checkbox"/> No <input type="checkbox"/> Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (Including tax)	Prescriber Name	Prescriber ID	
7. Is this a compound Rx? If Yes, please attach a Compound Claim form. <input type="checkbox"/> No <input type="checkbox"/> Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (Including tax)	Prescriber Name	Prescriber ID	

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

D. - Authorization (Completed by pharmacist/physician)

National Provider Indicator (NPI) number	Pharmacy Name				
Pharmacist / Physician Name	Address	City	State	ZIP	
Pharmacist / Physician Signature _____			Note: Payment for the above claim(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.		

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 due to an emergency or at a non-participating pharmacy.
2. You will be reimbursed directly for all covered services up to the allowed amount.
3. Complete all items in sections (A) and (B) for both cardholder and patient.
4. Sign the form in the area provided.
5. Include the ORIGINAL prescription receipt with this form and make copies for your records. Copies of the receipt will not be accepted for reimbursement.
6. Have your pharmacist complete sections (C) and (D) on the form.
7. For a list of participating pharmacies in your area, please refer to your member kit materials or call the customer service number on the back of your ID card.
8. Mail completed form to: **WellPoint NextRx - PO Box 145613 - Cincinnati, OH 45250-5613**

Pharmacist:

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

English: If you have any questions regarding this form, please contact one of our customer service representatives by calling the number on the back of your ID card or in your enrollment booklet.

Tagalog: Kung mayroon kang mga katanungan may kinalaman sa form na ito, mangyaring makipag-ugnayan sa isa sa aming mga customer service representative sa pamamagitan ng pagtawag sa numero na nasa likod ng iyong ID card o sa iyong booklet sa pagpapatala.

Vietnamese: Nếu quý vị có bất kỳ câu hỏi gì liên quan đến mẫu đơn này, xin vui lòng liên hệ với một trong những đại diện dịch vụ khách hàng của chúng tôi bằng cách gọi số điện thoại ở sau thẻ ID của quý vị hay ở cuốn sổ tuyển dụng.

Spanish: Si tiene alguna pregunta respecto a este formulario, por favor, comuníquese con nuestros representantes de servicio al cliente llamando al número que se encuentra al reverso de su tarjeta de identificación o en su folleto de inscripción.

Korean: 본 양식에 관한 문의사항이 있으시면 귀하의 ID카드 뒷면 또는 등록 책자에 있는 전화번호로 전화하셔서 고객 서비스 상담원에게 문의하여 주십시오.

Chinese: 如果你对此表格持有任何疑问，请致电您所持会员卡背后的或者是注册簿上的电话号码，以联系我