

## PRESCRIPTION DRUG CLAIM FORM

### INSURED INSTRUCTIONS — A separate claim form must be completed for each patient.

ATTACH RECEIPTS HERE

- Complete all information requested under Part A.
- If you used an WellChoice Pharmacy Management Participating Pharmacy, complete Part B using the information provided to you by your pharmacist and your receipt.
- If you did NOT use an WellChoice Pharmacy Management Participating Pharmacy, complete Part C using the information provided on the packaging of your prescription, on your receipt, or from your pharmacist.
- Review, sign, and mail completed form with receipt(s) to:  
WellChoice Pharmacy Management  
P.O. Box 5099  
Middletown, NY 10941-9099

**NOTE: Please allow up to 30 days for payment.  
If you have any questions regarding this form, please call WellChoice Pharmacy Management at 1-800-839-8442.**

**IMPORTANT: MISSING INFORMATION MAY CAUSE A DELAY IN PAYMENT.**

### Part A — INSURED/PATIENT INFORMATION

|                          |  |       |          |           |  |
|--------------------------|--|-------|----------|-----------|--|
| INSURED'S NAME: LAST     |  | FIRST |          | M.I.      | DAYTIME PHONE NUMBER<br>(      )   |
| INSURED'S STREET ADDRESS |  |       |          |           |  |
| CITY                     |  | STATE | ZIP CODE | GROUP NO. | INSURED'S ID NO. (ON ID CARD)  |
| PATIENT'S NAME: LAST     |  | FIRST |          | M.I.      | PATIENT CODE: (2 Digit code next to Patient's name on ID Card)   |
| PATIENT'S DATE OF BIRTH: |  | MONTH | DAY      | YEAR      | PATIENT'S RELATIONSHIP TO INSURED  |
|                          |  |       |          |           | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD |

Do you or your dependents have other insurance covering this claim and is the other insurance PRIMARY?  YES     NO  
IF "YES", please attach an Explanation of Benefits from your other insurance and a copy of the receipts.

### PART B - PARTICIPATING PHARMACY — PRESCRIPTION INFORMATION

List the claim authorization No. (also known as audit No.) for each prescription below and ATTACH ALL RECEIPTS for each prescription to this form.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

\*The Claim Authorization Number may be found on your receipt or ask your pharmacist for the number.

### PART C - NON-PARTICIPATING PHARMACY - PRESCRIPTION INFORMATION

All information below must be completed for reimbursement.

| NABP No. (7 digits) | DATE DISPENSED | Rx No. | NATIONAL DRUG CODE (11 digits) | DAYS SUPPLY | TOTAL PAID* |
|---------------------|----------------|--------|--------------------------------|-------------|-------------|
| 1.                  |                |        |                                |             |             |
| 2.                  |                |        |                                |             |             |
| 3.                  |                |        |                                |             |             |
| 4.                  |                |        |                                |             |             |

\*Actual amount paid by insured/patient to pharmacist.

**AUTHORIZATION:** I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, pharmacist, HMO, or prepayment organization to supply the Plan Administrator and its agents any information required in connection with this claim. A photocopy of this authorization shall be valid as the original.

INSURED'S SIGNATURE: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

# PRESCRIPTION DRUG CLAIM FORM FILING INSTRUCTIONS

In order to ensure that your claim is processed promptly and accurately, please follow these instructions when submitting a claim for prescription drug services. You must use the prescription drug claim form in order to receive reimbursement for your claims. Complete a separate form for each patient.

1. **For all prescription drug claims, complete Part A as follows:**
  - **Name - Address - Phone Number of insured.**
  - **Group No.** - This is the insured's designated group number. It is found on the insured's Prescription ID Card.
  - **Insured's ID No.** - The insured's Member Number is also found on the Prescription ID Card.
  - **Patient's Name, Date of Birth, and Relationship** to the insured.
  - **Patient Code** - This is the two digit number next to the patient's name on the Prescription ID Card. It is used to identify which family member received the prescription.
  - **Primary Insurance** - indicate if the patient has other insurance that would be considered primary which would also cover this claim. When one or more family members are covered under more than one group plan, primary indicates which carrier the claim should be submitted to first. Therefore, if the other insurance is primary, you must first submit your claim to that insurance carrier. In order to receive secondary coverage under WellChoice Pharmacy Management for the remainder, attach the **Explanation of Benefits (EOB)** from the other (primary) insurance carrier and a copy of the receipt.
  
2. **If you used a participating pharmacy, complete both Part A and Part B, as follows:  
(leave Part C blank)**
  - **Claim Authorization No.** - In some cases, this 8 digit number will appear on your receipt from the pharmacy. If not, be sure to ask your pharmacist for this number when you pick up your prescription. You must include this number when submitting a claim.
  - **Attach an original receipt** for each prescription to the upper left corner of the claim form.
  - **The insured should sign and date the authorization.**
  
3. **If you used a non-participating pharmacy, complete both Part A and Part C, as follows:  
(leave Part B blank)**
  - **NABP No.** - The NABP number is the seven digit National Association Board of Pharmacy number. If it is not on your receipt, ask your pharmacist for the number.
  - **Date Dispensed** - The date your prescription was dispensed.
  - **Rx No.** - This is the pharmacy's number for your prescription and is usually found on your receipt.
  - **National Drug Code** - This is an eleven digit number used as a drug identifier. You must record this number on your claim. If it is not on your receipt, ask the pharmacist for this number.
  - **Days Supply** - This represents the expected number of days the prescription will last (i.e., a prescription of 90 units taken 3 times per day represents a 30 day supply).
  - **Total Paid** - This is the amount you actually paid.
  - **Attach an original receipt** for each prescription to the upper left corner of the claim form.
  - The insured should sign and date the authorization.
  
4. **Send your completed claim form with attached receipts to:**

WellChoice Pharmacy Management  
P.O. Box 5099  
Middletown, NY 10941-9099

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