Prescription Claim Reimbursement Form

Mail completed form to WellPower Inc. • 410 Peachtree Pkwy Bldg 400 • Ste 4225 • Cumming GA 30041.
Incomplete forms will delay processing. Manual submission of claims does not guarantee reimbursement.

Step 1: Please complete all information. Member ID # and Rx Group # are located on your Prescription ID Card.

Member Information		**Prescription Plan Information**
Member Name:		Member ID #:
Address:		Rx Group #:
Birth Date:	Phone:	Employer:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent
Did condition result from employment? ☐ Yes ☐ No If Yes, date you last worked prior to treatment for which claim was made: ____/_____/_____

Step 2:

Submit original Prescription receipts or labels (not cash register receipt) that contain the requested information below. Please attach receipts to a separate page to be submitted with the claim form.

Step 3: If you do not have your original Prescription receipt, have your pharmacist complete below. A pharmacist signature is required.

Prescription Information			
Rx #:	Date Filled:	Quantity:	Day Supply:
Rx Name and Strength:	Physician Name: _____ Physician NPI #: _____		
NDC #:	Rx Price: $	Copay: $	New ☐ Refill ☐ (check one)

Rx #:	Date Filled:	Quantity:	Day Supply:
Rx Name and Strength:	Physician Name: _____ Physician NPI #: _____		
NDC #:	Rx Price: $	Copay: $	New ☐ Refill ☐ (check one)

Pharmacy Information			
Pharmacy Name:	Pharmacy Phone #:		
Street Address:	City:	State:	Zip:
Pharmacy NPI #:	Pharmacist Signature:		Date:

Part 4: Member, please read, sign and date below.
I certify that the above information is correct and the prescription information provided is for myself or eligible member of my family who have received the medication described. I authorize the release of all information contained on this claim form to WellPower and its related entities for the sole purpose of administering and processing my prescription benefits.

Member Signature: _____ Date: _____

Customer Service: 844.750.9012