Prescription Claim Reimbursement Form

Mail completed form to WellPower Inc. • PO Box 1864 • Doylestown • PA 18901 or email to: info@wellpoweronline.com.

Incomplete forms will delay processing. Manual submission of claims does not guarantee reimbursement.
This completed form must be submitted within 12 months after the date the medication was filled.

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

Cardholder Information		**Prescription Plan Information**
Cardholder Name:		Cardholder ID #:
Address:		Rx Group #:
Birth Date (MM/DD/YYYY):	Phone:	Employer:

Patient Information	
Patient Name: Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Dependent	Birth Date (MM/DD/YYYY):
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 sheet and submit 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 #:	Patient Cost: $		New ☐ Refill ☐

Rx #:	Date Filled:	Quantity:	Day Supply:
Rx Name and Strength:	Physician Name: _____ Physician NPI #: _____		
NDC #:	Patient Cost: $		New ☐ Refill ☐

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

Part 4: Please read, sign and date below.

I certify that the information provided is accurate and 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. All medications described herein were received by the named patient and he/she is eligible for benefits. None of the named medications described herein are covered under another benefit plan or for an on-the-job injury.

Patient (or Guardian) Signature _____ Print Name _____ Date _____

Customer Service: 833.200.5040