Prescription Cap Reimbursement Form

Member Information

Name _____

Member ID # _____

Phone Number _____

Email Address _____

Member DOB _____

Pharmacy Information

Pharmacy Name _____

Please List All Medications Filled:

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*** Copies of all Receipts including name/type of Medication in addition to Receipt for Proof of Payment MUST be attached for reimbursement.**

*** Please separate receipts by month and complete one form for each month.**

Please email completed form to keepitlow@wellhealthqc.com

Internal Use Only

Received By _____ Date _____ Submitted _____