

Control is the Goal: Diabetes Reimbursement for Prescription Cap

Member Information

Name _____

Member ID # _____

Phone Number _____

Email Address _____

Member DOB _____

Pharmacy Information

Pharmacy Name _____

Medications Filled (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> 2710 – Insulin | <input type="checkbox"/> 2728 – Meglitinide Analogues |
| <input type="checkbox"/> 2720 – Sulfonylureas | <input type="checkbox"/> 2760 – Insulin Sensitizing Agents |
| <input type="checkbox"/> 2725 – Biguanides | <input type="checkbox"/> 2799 – Antidiabetic Combinations |
| <input type="checkbox"/> 2730 – Diabetic Other | <input type="checkbox"/> 2715 – Antidiabetic – Amylin Analogs |
| <input type="checkbox"/> 2717 – Incretin Mimetic Agents (GLP-1 Receptor Agonists) | |
| <input type="checkbox"/> 2750 – Alpha-Glucosidase Inhibitors | |
| <input type="checkbox"/> 2755 – Dipeptidyl Peptidase-4 (DPP-4) Inhibitors | |
| <input type="checkbox"/> 2770 – Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors | |

*** Please attach a copy of Receipt with name/type of Medication in addition to Receipt for Proof of Payment.**

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

Please email completed form to controlisthegoal@wellhealthqc.com

Internal Use Only

Received By _____

Date _____

Submitted _____