LIMITED BENEFIT GROUP SUPPLEMENTAL OUTPATIENT PRESCRIPTION DRUG
MEMBER CLAIM FORM

Submitting your claim
Submit your claim the way you like via mail, email, online portal, or fax:

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

Email: claims@bbadmin.com
Portal: portal.bbadmin.com
Fax: 512-275-9350

This form can be found on our website at www.wellfleetinsurance.com or bbadmin.com

Questions?
If you have any questions regarding benefits available, or how to file your claim, or if you would like to appeal any determination, please contact our Customer Service Center at

- 1-855-900-4777, 8:00 AM to 5:00 PM CST
- claims@bbadmin.com

Please read the following instructions and complete this form carefully:

A prescription receipt or pharmacy printout from the dispensing pharmacy is required for each prescription for which a claim is being submitted.

The drugs for which you are requesting payment must be clearly identified on the receipt or history and include the following information: Dispense Date, 11-digit National Drug Code (NOC), Medication Name, Strength, Dose, Quantity, Days' Supply, Amount Paid, Prescriber's Name, the Prescriber's National Provider Information (NPI) Number, and the Total Cost of the prescription.

- Please submit your receipts **TAPED** to a separate piece of paper with this form.
- Fill out Step 1: Member Information
- Fill out Step 2: Authorization for Release of Health-Related Information
- Fill out Step 3 ONLY if information is missing from your receipt OR Step 3 can be completed by your pharmacist or physician IF you do not have a receipt
- Fill out Step 4: Member Signature

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

STEP 1: MEMBER INFOMRATION

Cardholder ID#: _____ Group Number: _____

Cardholders Name: Last: _____ First: _____ MI: _____

Mailing address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

STEP 2: AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO BAY BRIDGE ADMINISTRATORS, LLC

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, Pharmacy Benefit Manager (PBM), medical facility, or other health care provider that has provided payment, treatment or services on behalf of the Insured named below within the past 1O years ("Providers") to disclose the entire medical record and any other protected health information concerning the Insured named below to Bay Bridge Administrators. LLC and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Bay Bridge Administrators. LLC may:

1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the Insured named below has with Bay Bridge Administrators. LLC.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that: (A) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in, Arizona, Georgia, Illinois, Minnesota, New Jersey, New Mexico, North Carolina, Ohio or Virginia, this Authorization shall not remain valid for longer than: (1) the term of coverage of the policy if the claim is for a health insurance benefit; or (2) the duration of the claim if the claim is not for a health insurance benefit; and, (B) as to HIV-related information only, if the Insured resides/resided in Arizona, this Authorization shall remain valid for 180 days; and, (C) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in Wisconsin, this Authorization shall remain valid for the policy term or the pendency of a claim for benefits under the policy, whichever is longer. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Bay Bridge Administrators. LLC at P.O. Box 161690, Austin, TX 78716, Attention: Claims Department. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Bay Bridge Administrators. LLC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record of the Insured named below, Bay Bridge Administrators. LLC may not be able to make any benefit payments. I understand that the Insured or Insured's authorized representative may request a copy of this Authorization.

Name of Insured or covered Dependent if over 18 (please print)

X

Signature of Insured or Dependent if over 18 Date

Description of Personal Representative's Authority

Step 3. Enter Information from Prescription Drugs
(Complete only if information is missing from the receipt or if you do not have a receipt)

Drug Name & Strength	NDC (National Drug Code)	Quantity Dispensed	Ingredient Cost	**Day's Supply**	**Vaccine Administration Fee or Dispensing Fee**	**Total Cost**

Pharmacy Name: _____

Pharmacy NPI Number: _____

Prescribing Physician Name: _____

Prescribing Physician NPI Number: _____

If you do not have a receipt this section must be completed and signed by a pharmacist or physician.

Pharmacist or Physician Signature: _____

FRAUD NOTICES

For residents of all states, other than those listed below: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana, and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

STEP 4: MEMBER SIGNATURE

Claim payments are subject to satisfaction of any applicable Outpatient Prescription Drug Deductible and Policy Deductible. Total benefits payable during a Plan Year may not exceed the Outpatient Prescription Drug Maximum Benefit per Plan Year per Covered Person or per Family, as applicable.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

By signing, you acknowledge that the above information is true to the best of your knowledge and belief.

Signature: _____ Date: _____

WELLFLEET
WORKPLACE

BAY BRIDGE ADMINISTRATORS

DIRECT DEPOSIT REQUEST AUTHORIZATION

Name on Account:

_____ ___ _____

First Name MI Last Name

SSN: _____

Address on Account:

_____ _____ ____ _____

Street Address City State Zip

Phone: _____ **Email:** _____

Banking Information:

_____

Bank Name

_____ _____ **Account type**: ☐ Checking

Routing Number (9 digits) Account Number ☐ Savings

ATTACH VOIDED CHECK HERE

I (we) authorize { BBA/Wellfleet} to initiate credit entries to my (our) account indicated above.

_____ _____

Authorized Signature Date

Please return form with filed claim to:

Name: Bay Bridge Administrators, LLC.
Address: P.O. Box 161690
Address: Austin, TX 78716
Phone: (855) 900-4777
Fax: (512) 275-9350
Email: claims@bbadmin.com