PRESCRIPTION DRUG CLAIM FORM

Pharmacy Services
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Please use this form to submit a claim for covered prescriptions sold by licensed pharmacists. Copies of more than one receipt may be included with this form, but please submit a separate form for *each patient*. The deadline for submitting claims is one year from the date the prescription was filled.

1. Complete, sign, and date this form. Find your group and member ID numbers on your member ID card.
2. Attach copies of your cash register receipt and pharmacy receipt (similar to the bottle label) to the back of this form. If you have primary coverage through another plan (double covered), please also attached a copy of that plan's Explanation of Benefits (EOB) statement *or* printout from the filling pharmacy.* Please use tape instead of staples, and attach as many pages as needed.
3. Return this form with your receipt copies to our Claims Department. We will make every effort to complete the processing of your claim within 30 days of receiving it. If we need more information or if there is a delay, we will contact you.

If you have any questions, please contact us. A representative will be happy to assist you.

YOUR INFORMATION

Employer or policyholder: ________________________ Group number: ________________

Your last name: ____________________ First name: ________________ Middle initial: ____

Member ID number: ________________________ Birth date (mm/dd/yyyy): ____________

Street address: ____________________ City: ____________ State: ____ Zip: ________

Daytime phone: ____________________ Email: ____________________________

Patient's last name: ____________________ First name: ________________ Middle initial: ____

Relationship to you: ☐ Self ☐ Spouse or domestic partner ☐ Child

YOUR SIGNATURE

I hereby certify that all information is correct.

Your signature: ______________________________ Date: ____________________

PHARMACY RECEIPT

In addition to a copy of your cash register receipt, please attach a copy of the *pharmacy* receipt. The pharmacy receipt is similar to the bottle label and is usually stapled to or in the bag containing your medication. The pharmacy receipt must include:

- Dispensing pharmacy name
- Prescribing doctor/nurse practitioner name
- Date prescription was filled
- NDC (National Drug Code) number
- Medication name and strength
- Quantity of drug dispensed and the number of days it is for (example: #30 /30 days)

* PRIMARY COVERAGE THROUGH ANOTHER HEALTH PLAN (DOUBLE COVERAGE)

Note: Starting in 2017, you will need to also include a copy of your Explanation of Benefits (EOB) statement from your primary carrier *or* printout from the dispensing pharmacy, with the pharmacy receipt and this form. The explanation of benefits statement or pharmacy printout must include:

- Amount paid by primary plan
- Amount you paid (such as co-pay)
- Total cost of medication

Number of pages attached to this form: __________