

PRESCRIPTION DRUG CLAIM FORM

In order to process your claim(s), you must provide all information requested below. Submit the completed form with the original pharmacy prescription label/receipt(s)

Primary Member/Cardholder Information

Primary Member/Cardholder ID Number	Primary Member/Cardholder Name (First, Middle, Last)		
Name of Health Plan/Insurance	Member Phone Number (Day)	Member Phone Number (Evening)	
	() -	() -	
Address (Street)	(City)	(State)	(Zip Code)

Patient Information (if different than Primary Member's/Cardholder's)

Patient's Name (First, Middle, Last)	Patient's DOB (MM/DD/YYYY)	Relationship to Primary Member/Cardholder		
		Spouse	Dependent	Other
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Address (Street)	(City)	(State)	(Zip Code)	

Other Coverage Information

Covered under any other insurance? Coordination of Benefits (COB) <input type="checkbox"/>	Worker's Compensation? <input type="checkbox"/>
If COB, please indicate the name of primary insurance here:	
	If Worker's Compensation is selected, please stop and submit claim to your employer.

*Submit either **prescription receipts/labels** with the following information – and/or have your **pharmacist** sign and complete the Prescription Details.

Prescription Details

- Pharmacy Name/Address
- Prescription Number & Date Filled
- Physician's Name or DEA #
- Drug Name & Strength or NDC #
- Quantity and Day Supply Dispensed
- Member Paid Expense

1) Rx Number	Date Filled	Check One New <input type="checkbox"/> Refill <input type="checkbox"/>	Quantity	Day Supply	Directions	Total Price w/Tax \$
Medication Name, Strength and Form (OR - NDC # below)			Vac Admin Fee	DAW (0-8)	Prescribing Physician's Name/DEA #	Compound Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, see pg.2
NDC # (11-digit)			COB Claim? Yes <input type="checkbox"/> No <input type="checkbox"/>		COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer	Copay Paid \$
2) Rx Number	Date Filled	Check One New <input type="checkbox"/> Refill <input type="checkbox"/>	Quantity	Day Supply	Directions	Total Price w/Tax \$
Medication Name, Strength and Form (OR - NDC # below)			Vac Admin Fee	DAW (0-8)	Prescribing Physician's Name/DEA #	Compound Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, see pg.2
NDC # (11-digit)			COB Claim? Yes <input type="checkbox"/> No <input type="checkbox"/>		COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer	Copay Paid \$
3) Rx Number	Date Filled	Check One New <input type="checkbox"/> Refill <input type="checkbox"/>	Quantity	Day Supply	Directions	Total Price w/Tax \$
Medication Name, Strength and Form (OR - NDC # below)			Vac Admin Fee	DAW (0-8)	Prescribing Physician's Name/DEA #	Compound Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, see pg.2
NDC # (11-digit)			COB Claim? Yes <input type="checkbox"/> No <input type="checkbox"/>		COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer	Copay Paid \$

Pharmacy Information

Pharmacy Name			Pharmacy Telephone Number		
Street Address			NABP		
City	State	Zip	Pharmacy Signature		Date

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. I also authorize payment to subscriber unless I have indicated a different payee above.

Claimant Signature X

COMPOUND PRESCRIPTIONS

*** Pharmacy or dispensing facility must complete the remaining portion and return this to member**

- Enter the NDC number of the MOST expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the metric quantity dispensed in number of tablets, grams or mls for liquids, creams, ointments, and injectables.
- Indicate the amount paid for the prescription by the patient.

COMPOUND PRESCRIPTIONS			
*For pharmacy use only			
NDC#	Drug Ingredient	Quantity	Charge
Total Charge:			\$

Note: If purchased in a foreign country, the currency must be converted into US dollars.

- The original paid pharmacy prescription label/receipt (including the required drug information) MUST accompany this claim form. Pharmacy receipts will not be returned, you may wish to make copies for your records.