ATTN: CLAIMS DEPT
MedImpact Healthcare Systems, Inc. 10680 Treena Street 5th floor San Diego, CA 92131
Fax to: (858) 549-1569

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). Documents provided, other than original pharmacy receipts (i.e., prescription profiles) must be signed by the pharmacist and include the following information: NDC, quantity, day supply, Rx # and fill date, DEA#, NABP, and amount member paid).

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 ❑
Address (Street)	(City)	(State)	(Zip Code)	

Other Coverage Information

Covered under any other insurance? Coordination of Benefits (COB) ☐	Is Medicare the Primary Prescription Coverage?	Worker's Compensation? ❑
If COB, please indicate the name of primary insurance here: _____	Yes ☐ No ☐	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	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	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	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	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	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	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.

Claimant Signature **X**

Warning it is a crime to provide false information 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 claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any persons knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

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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. Any documents provided other than the original pharmacy receipts (i.e. prescription profiles, etc.), must be signed by the pharmacist and include the following information: NDC, quantity, day supply, rx # and fill date, DEA#, NABP, and amount member paid. Pharmacy receipts will not be returned, you may wish to make copies for your records.