# Prescription Reimbursement Claim Form

**Important!**

- Allow up to 30 calendar days for processing to receive a response to your claim
- Keep a copy of all documents submitted for your records
- Do not staple receipts or attachments to this form
- Reimbursement is not guaranteed and may not equal the amount paid
- You must submit claims within 1 year of date of purchase or as required by your plan

## STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

### Card Holder Information

Identification Number (refer to your member ID card)

Group Number/Group Name

Last Name

First Name MI

Address

Address 2

City

State Zip Country

### Patient Information–Use a separate claim form for each patient

Last Name

First Name MI

Date of Birth / / Male Female Phone Number

Relationship to Primary Member

Member Spouse Child Other _____

### Pharmacy Information–Use a separate claim form for each pharmacy

Pharmacy Name

Address

City State Zip

**REQUIRED:** Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (Tape receipts and/or itemized bills on another sheet of paper)

### Reason I am filing this form is:

- ☐ Claim rejected at pharmacy
- ☐ Compound
- ☐ Out of coverage area Other–
- ☐ provide reason below

_____

_____

_____

PLEASE INDICATE:

State: _____

### Other Insurance Information

#### Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury?

☐ YES ☒ NO

Is the medicine covered under any other group insurance? ☐ YES ☐ NO

If YES, is other coverage:

☐ PRIMARY ☐ SECONDARY

☐ MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

_____

_____

ID#: _____

*Continued*

## Pharmacy Information Continued

Phone Number | Is this an on site nursing home pharmacy? YES NO | NCPDP/NPI Required

X

**Signature of Pharmacist or Representative (REQUIRED)**

## Important! A signature is REQUIRED

### NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

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

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X

**Signature of Plan Participant (REQUIRED)** **Date**

## STEP 2 Submission Requirements

**You MUST include all original "pharmacy" receipts for your claim to be reviewed. Cash register receipts will ONLY be accepted for diabetic supplies. You may need to ask for a special receipt.**

**The minimum information that must be included on your pharmacy receipts is listed below:**

- Patient Name
- Prescription Number
- Medicine NDC Number
- Date of Fill
- Amount and Type of Drug (4 tablets, for example)
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Days Supply" information)
- Pharmacy Name and Address or Pharmacy NCPDP Number

**Please provide a valid Prescribing Physician's NPI:** _____

**Prescribing physician's information:**

**Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____

**Additional comments:** _____

_____

## STEP 3 Mail completed forms with receipts to:

**Claims Department**
**P.O. Box 52065**
**Phoenix, AZ 85072-2065**

OR

## Fax completed forms with receipts to:

**Fax: 401-404-6344**

### IMPORTANT REMINDER – To avoid having to submit a paper reimbursement claim form:

- Always have your ID card available at time of purchase
- Always use pharmacies within your plan
- Use medication from your preferred drug list
- Return to the pharmacy to request claim reprocessing and for reimbursement
- If problems are encountered at the pharmacy, call the Pharmacy Member Services number on your ID card

Reset Form