

# 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

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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:

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ID#: \_\_\_\_\_

## 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.

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