Prescription Drug Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

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Member/Subscriber Information *See your Member ID card.*

Group No. FORJALA

Prescription ID card number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID Card Holder Name (First, Last)

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex
☐ Female
☐ Male

Relation to Plan member
☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Domestic Partner
☐ 7 Other
☐ 8 Non-spouse Partner

Pharmacy Information

Name of Pharmacy

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

I hereby certify that the charge(s) shown for the medications prescribed is (are) correct and agree to provide Medco Health or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the Plan member and assignment of these benefits to a pharmacy or otherwise is void.

X
Signature of Pharmacist or Representative **(Required)**

NABP Number Required

Claim Receipts

Tape prescription claim receipts on the back.
Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

☐ **is a compound prescription.**
If so, make sure your pharmacist lists all the ingredients and quantities on the receipt.

☐ **was purchased outside the U.S.A.**
If so, please indicate:

Country _____

Currency used _____

☐ **is for treatment of an allergy.**

Coordination of Benefits

Is this a coordination of benefits claim?

☐ Yes ☐ No

If "Yes," is this plan ☐ Primary, or ☐ Secondary

If "Secondary," check the primary payment method below. See the back for additional information.

☐ 1 Major Medical (attach an Explanation of Benefits from the Primary Insurer)
☐ 2 Card Program
☐ 3 HMO
☐ 4 Mail Service

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am/are eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury. I further authorize the use of my Social Security Number or other ID number for identification purposes. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X
Signature of Member

Claim Receipts

Please tape your receipts here. **Do not staple!**

Tape receipt for Rx 1 here

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (Drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for Rx 2 here

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tape receipt for Rx 3 here

Tape receipt for Rx 4 here

Direct Reimbursement Claim Instructions
Read carefully before completing this form

1. Always present your prescription ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid a pharmacy full price for a prescription drug order because:
   - the pharmacy does not accept your prescription ID card, or
   - you have not received your prescription ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient**.
4. You must submit claims within one year of date of purchase or as required by your Plan.
5. **Be sure your receipts are complete**. In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
6. The ID Card Holder should read the Acknowledgment carefully, then sign and date this form.
7. Return the completed form and receipts to:

   Medco Health
   P.O. Box 2187
   Lee's Summit, MO 64063-2187

Visit us on the web at **www.medcohealth.com**

Form# C300197

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