



P.O. Box 5300
 Poland, Ohio 44514
 1.800.800.7364, ext. 5402

Prescription Drug Claim Form

CLAIM MUST BE FILED WITHIN
 ONE (1) YEAR OF PURCHASE DATE.

PART 1

*Indicates required information

Primary member/subscriber ID number*		Group number		
Group/employer name		Primary subscriber name*		Subscriber date of birth (mm/dd/yyyy)* / /
Patient name (first, middle, last)*		Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (mm/dd/yyyy)* / /	Relationship to primary subscriber Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Domestic Partner <input type="checkbox"/>
Address (Street, City, State, ZIP Code)				
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.				
Member signature*		Telephone number ()		Date / /

Indicate reasons for filing a claim(s) (select one)*

<input type="checkbox"/> Coordination of benefits—claims must be submitted with pharmacy receipts(s) identifying copays paid <u>and</u> an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing insurance payment) <input type="checkbox"/> Medicare is primary prescription coverage <input type="checkbox"/> Discount card was used <input type="checkbox"/> Health plan, insurance information or insurance card was not available at the time of purchase <input type="checkbox"/> Pharmacy not participating in network <input type="checkbox"/> Pharmacy unable to process claim electronically <input type="checkbox"/> Emergency—please explain _____ <input type="checkbox"/> Workers' compensation <input type="checkbox"/> Prescription purchased outside the U.S. <input type="checkbox"/> Other _____
Submission of claims does not guarantee reimbursement.

PART 2

Rx number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)* _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _				
Medication name and strength*			Physician name and NPI number Name _____ NPI _____		Rx price* \$	Vaccine admin fee \$	Copay* \$		

Is this a compound? Yes No

PART 3

Affix pharmacy label here or enter the required information

Pharmacy name*			Pharmacy telephone number		
Street address			NPI*		
City	State	ZIP code	Pharmacy representative signature*		Date* / /

Please mail this form with your RECEIPT to Pharmacy BenefitDirect, P.O. Box 5300, Poland, Ohio 44514.

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