PDMI
Innovative Ideas. Better Lives.

P.O. BOX 5300
Poland, Ohio 44514
1.800.800.7364

Prescription Drug Claim Form

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

***Indicates required**

PART 1

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 ☐ Female ☐	Date of Birth (mm/dd/yyyy)* / /	Relationship to primary subscriber Self ☐ Spouse ☐ Dependent ☐ Domestic Partner ☐
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)*

☐ Coordination of benefits- claims must be submitted with pharmacy receipts(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing insurance payment)
☐ Medicare is primary prescription coverage
☐ Discount card was used
☐ Health plan, insurance information or insurance card was not available at the time of purchase
☐ Pharmacy not participating in network
☐ Pharmacy unable to process claim electronically
☐ Emergency-please explain _____
☐ Workers' compensation
☐ Prescription purchased outside the U.S.
☐ Other_____

Submission of claims does not guarantee reimbursement.

PART 2

RX number	Date filled* / /	New☐ Refill☐ (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	Pharmacy representative signature*	Date* / /

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

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RX number	Date filled* / /	New☐ Refill☐ (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

RX number	Date filled* / /	New☐ Refill☐ (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* $

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Is this a compound? ☐Yes ☐No