

Pharmacy Reimbursement Claim Form

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

Member/Subscriber Information *See your ID card.*

RxGrp

Member ID

Member Name (First, Last)

Street Address

City

State

Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Gender Relationship to Member/Subscriber

- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self | <input type="checkbox"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male | <input type="checkbox"/> 2 Spouse | <input type="checkbox"/> 6 Dependent Parent |
| | <input type="checkbox"/> 3 Eligible Child | <input type="checkbox"/> 7 Nonspouse Partner |
| | <input type="checkbox"/> 4 Dependent Student | <input type="checkbox"/> 8 Other |

Pharmacy Information

Name of Pharmacy

Street Address

City

State

Zip

Telephone (include area code)

X

Signature of Pharmacist or Representative
(If required by your pharmacy plan)

NCPDP#/NPI# (Pharmacy Account Number)
(11 Digit Number)

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury. 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/Subscriber **(required to process)**

Claim Receipts

(Please read Section A on back for details.)

Check the appropriate box if your receipts are for a:

- Compound prescription**
Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the receipt.
- Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____
- Allergy medication** (if covered by your pharmacy plan)

Coordination of Benefits

(Another Health Plan has paid a portion)
Is this a coordination of benefits claim?

Yes No

If yes, please read Section B on back for details, and mark the appropriate box for your primary coverage method.

- 1 You are submitting an Explanation of Benefits (EOB) from another Health Plan or from Medicare
- 3 You are submitting a copay receipt

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 and/or imprisonment, or denial of benefits.*

Please tape receipts on the back.

