

Prescription Drug Claim Form



Member information

ID number

Date of birth / / Male Female

Name (First, Last) _____

Street address _____

City _____ State _____ Zip _____

Member's relationship to primary cardholder:
 Self Spouse Dependent

I certify that:

- The information on this form is correct
- The member named above is eligible for pharmacy benefits
- The member named above received the medicine(s) listed
- These benefits have not been assigned; any further assignment is void
- I give my permission to share the information on this form with Prime Therapeutics LLC

Member or legal representative signature

Is this medicine for an on-the-job-injury? Yes No

Do you have other insurance for this prescription medicine? Yes No

If yes, what is the other insurance company's name? _____

Cardholder information (primary policyholder)

Name (First, Last) _____

Why are you submitting this Prescription Drug Claim Form?
(check one)

- Did not have my pharmacy card with me
- Have not received my pharmacy card
- Picked up my medicine from a non-network pharmacy
- My other insurance is paying for part of this medicine (attach that company's Explanation of Benefits and an itemized receipt)
- Other (please explain) _____

Pharmacy information

Pharmacy name _____

Pharmacy address _____

City _____ State _____ Zip _____

Prescription (Rx) claim information

Was this prescription medicine purchased outside the U.S.? Yes No

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach itemized pharmacy receipts to the back of this form.

1 Rx number

Date filled / /

Quantity _____ Days' supply

Name of medicine _____

NDC number
(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

NPI number

Prescription cost \$.

Balance due \$.

2 Rx number

Date filled / /

Quantity _____ Days' supply

Name of medicine _____

NDC number
(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

NPI number

Prescription cost \$.

Balance due \$.

Pharmacy/prescription (Rx) information

1. Use a separate claim form for each member. All information provided on or attached to this claim form must be for the same person.
2. Attach itemized pharmacy receipts from your prescription bag. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

Required information

- Member name
- Pharmacy name and address
- Total charge
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply

Questions?

- You can call the number on the back of your member ID card
 - Your pharmacist may call 855.457.0408
3. Send this completed form with itemized receipts to:

Prime Therapeutics
 Mail route DTE
 P.O. Box 21870
 Lehigh Valley, PA 18002-1870

EXAMPLE

Rx number

Date filled

Quantity Days' supply

Name of medicine "Drug Name"

NDC number
(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

NPI number

Prescription cost \$

Balance due \$

Is this prescription claim for a compound medicine?
 Yes No

Note: If yes, make sure your pharmacist completes the information below.

Compound Information

Please enter all information for each drug used.

Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1	Rx 2
<p>Attach itemized pharmacy receipts here</p> <p>All required information must be visible (see step 2 above).</p> <p>Keep a copy of your receipt(s) for your records.</p>	<p>Attach itemized pharmacy receipts here</p> <p>All required information must be visible (see step 2 above).</p> <p>Keep a copy of your receipt(s) for your records.</p>