Prescription Drug Reimbursement / Coordination of Benefits Claim Form

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

›› Cardholder Information *See your prescription drug ID card.*

Group No.

Member ID

Member Name First Last

Street Address

City State ZIP

›› Patient Information

Patient Name First Last

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

Sex *Relationship to Plan Member*

›› Acknowledgment

I certify that the medication(s) described 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 certify that the medication(s) described were not for an on-the-job injury. *By completing this form, 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 Date

*If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form.

Claim Receipts

Please tape your receipts here. Do not staple! If you have additional receipts, tape them on a separate piece of paper

Tape receipt for prescription 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 day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 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 day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid