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 U H E A L T H

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
☐ Female
☐ Male

Relationship to Member/Subscriber
☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Nonspouse Partner
☐ 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)

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.

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

Instructions

Read carefully before completing this form

1. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed below. Your pharmacist can provide the necessary information if your claim is not itemized.
2. The member/subscriber should read the acknowledgment carefully, then sign and date this form.
3. **Return the completed form and receipt(s) to:** **Medco Health Solutions, Inc.**
   P.O. Box 14711
   Lexington, KY 40512

Section A – Claim Receipts

Please tape your pharmacy receipts (not the cash register receipt) to this side of the claim form. **Please do not staple.**

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 days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

TAPE YOUR PHARMACY RECEIPTS HERE

If you have additional receipts tape them to a separate piece of paper.

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11 digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity
Total Quantity	
Total Charge	

Section B – Coordination of Benefits

- You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
- You must submit claims within one year of date of purchase or as required by your plan.

You are submitting an Explanation of Benefits (EOB) from another Health Plan or from Medicare

If you have not already done so, submit the claim to the Primary Plan or Medicare. Once the EOB is received, complete this form, tape the original prescription receipts in the spaces provided above, and attach the EOB from the Primary Plan or Medicare, which clearly indicates the cost of the prescription and what was paid by the Primary Plan or Medicare.

You are submitting a copay receipt

If your Primary Plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB

* Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

* California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

* Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.