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
- ☐ 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 NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM
PER COMPOUND SUBMISSION

☐ **Medication purchased outside of the United States**
Please indicate:
Country______
Currency used______

☐ **Allergy medication**
(if covered by your pharmacy plan)

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

Pharmacy Reimbursement Claim Instructions
Read carefully before completing this form.

1. Always present your ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid full price for a prescription medication order at a pharmacy because:
   - The pharmacy does not accept your ID card, or
   - You have not received your ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
4. You must submit claims within 1 year of date of purchase or as required by your plan.
5. **Be sure your receipts are complete.**
   In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member/subscriber should read the acknowledgment carefully, then sign and date this form.
7. **Return the completed form and receipt(s) to:**
   Medco
   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.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

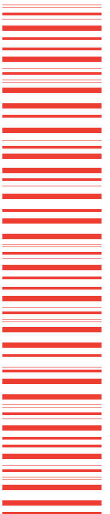
RX #		Date filled		Days' supply	

VALID 11-digit NDC #	Quantity	Price
Total quantity		
Total charge		

* 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.



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