State University of New York
Prescription Reimbursement Form

HTH Worldwide

Please use a separate claim form for more than two prescriptions. Your cooperation in completing all items on the claim form, signing the back of the form and attaching all required documentation will help us to process your claim quickly and accurately.

PATIENT INFORMATION			INSURED INFORMATION (on ID Card)	
NAME: Family Name Given Name			Certificate Number:	Group Name:
Birth Date MM DD YY	Gender	Relationship to Insured member	NAME: Family Name Given Name	
	☐ M ☐ F	☐ Self ☐ Son ☐ Spouse ☐ Daughter	Reimbursement Mailing Address:	
Does The Patient Have Other Health Insurance Coverage? ☐ Yes ☐ No				
Name of Other Health Insurance Company:				
Policy Number			Contact Phone Number:	Email Address:

PRESCRIPTION (Rx) INFORMATION

Each prescription submitted for reimbursement MUST include the drug quantity, drug name and strength. Be sure to **tape** the original paid pharmacy receipt(s) to the form and enter the total of both drug receipts in the space marked "TOTAL COST".

Tape original pharmacy receipt with prescription detail HERE	Tape original pharmacy receipt with prescription detail HERE

Total cost of prescriptions claimed: $ _____

AUTHORIZATION

Certification and Release of Information: I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. If I checked the Pay the Provider box above, I authorize payment directly to those Health Care Providers described below, and/or indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them. This claim will be returned if this claim form is not signed.

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

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

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Applicants applying for accident and health insurance in New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Oklahoma**, **WARNING**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In **Kentucky and 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.

In **Washington**, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

X _____ _____

Signature of Insured Member | Date

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

INSTRUCTIONS:

1. Provide the PATIENT/INSURED and PRESCRIPTION Information requested below. (PLEASE PRINT).
2. Complete a separate claim form for **each patient.**
3. The **original paid pharmacy receipts** showing prescription detail **must be taped to the form.** A cash register receipt is **not** satisfactory evidence of purchase. If you have more than two receipts for the same patient, use another form.
4. Remember to sign the form and enter the total amount of your receipts in the space provided.
5. Mail your prescription drug claims to the address above and keep a copy for your records.

SEND COMPLETED CLAIM FORM AND SUPPORTING DOCUMENTATION TO:

HTH Worldwide Insurance Services

P.O. Box 21545

Eagan, MN 55121

1.888.350.2002

Fax: 1.215.761.0391