PRESCRIPTION DRUG CLAIM FORM

DO NOT STAPLE IN THIS AREA

[redacted]

☐ **Please check this box if you have prescription drug benefits through another insurance carrier and you are submitting copayments to us.**

A Cardholder Information:

Cardholder ID #: _____

Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

B New Document:

STARK COUNTY SCHOOLS

C Prescription was dispensed to:

Patient Name: _____ Patient Birthdate: __ __/__ __/__ __ __ __ Sex: ☐ M ☐ F
Last First MI

Patient Relationship to Cardholder (Check one box) ☐ Cardholder (C) ☐ Spouse (S) ☐ Child (D) ☐ Other Dependent (O)

NOTE: Use a separate claim form for each Prescription Drug Claim.

I certify that the above information is correct and that I have received the drug described below. I also certify that the patient for whom this claim is made is eligible for benefits. The drug listed below is not for treatment of an occupational injury or disease, for which the Employer has accepted liability.

I authorize the pharmacy or physician to furnish the administrator with any information relating to the prescription listed below.

Signature _____

E Please attach single Prescription Receipt inside the box below

Please tape one receipt in this box

NOTE: Payment for the above claim will be made directly to the covered individual. Any assignment of these benefits is void.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

INSTRUCTIONS

Please read this carefully before completing the claim form. Claim forms without the required information will be returned.

PATIENT INSTRUCTIONS

1. Bring the claim form to the pharmacy when you obtain a prescription.
2. Each prescription **must have an original prescription receipt** returned with the claim form. A cash register tape is **not** satisfactory evidence of purchase.
3. A separate claim form must be used for each prescription.
4. You must complete Sections A, C and E.
5. **If you have prescription drug benefits through another insurance carrier please submit along with your other carrier Explanation of Benefits. Just complete sections A & C and attach your receipt in Section E.**
6. Submit this claim form to Medical Mutual Services.

Enclose your completed claim form (including the original receipt) in an envelope and mail to:

To: POOL CLAIMS EAST
MAIL ZONE: 01-1N-4321
MEDICAL MUTUAL
2060 EAST 9TH ST.
CLEVELAND, OHIO 44111