165 Court Street, Rochester, New York 14647

Mail Completed Claims To: **FLRx**
PO Box 22999
Rochester, NY 14692

Subscriber Prescription Drug Claim Form

Subscriber's Full Name

Address

City, State, Zip Code

If your address has changed or is incorrect, please call our Customer Service Department as instructed on the back of the form.

Subscriber identification number:

1. Patient Information:

Patient's full name:

Sex: ☐ Male ☐ Female

Relationship to subscriber: ☐ 1. Self ☐ 3. Child ☐ 2. Spouse ☐ 4. College Student

Patient's date of birth:

If treatment was the result of a non-work injury, give date of injury:

If other than USA, in what country was patient treated?

Patient diagnosis *(illness/injury which required treatment):*

2. Motor Vehicle Injury or Illness: ☐ NO ☐ YES

Work Related Injury or Illness: ☐ NO ☐ YES

Other Insurance Carrier: ☐ NO ☐ YES

(Please see back for instructions if you are submitting for Coordination of Benefits)

3. Claim Date and Subscriber Signature: *(Unsigned claims will be returned.)*

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation. In addition, I hereby authorize any insurance company, organization, employer, hospital, doctor or any other provider of service to release any information requested relevant to this claim and any attached bills.

Date: ___/___/___ **Subscriber's signature:** ____________________

4. Pharmacist to Complete This Section:

Charge ☐☐☐☐.☐☐ | Date Rx Filled (MM/DD/YY) ☐☐/☐☐/☐☐ | National Drug Code (NDC) ☐☐☐☐☐☐☐☐☐☐☐ | Days Supply ☐☐☐

Prescription Number ☐☐☐☐☐☐☐ | Quantity ☐☐☐☐☐ | Drug Name and Strength __________

Charge ☐☐☐☐.☐☐ | Date Rx Filled (MM/DD/YY) ☐☐/☐☐/☐☐ | National Drug Code (NDC) ☐☐☐☐☐☐☐☐☐☐☐ | Days Supply ☐☐☐

Prescription Number ☐☐☐☐☐☐☐ | Quantity ☐☐☐☐☐ | Drug Name and Strength __________

Charge ☐☐☐☐.☐☐ | Date Rx Filled (MM/DD/YY) ☐☐/☐☐/☐☐ | National Drug Code (NDC) ☐☐☐☐☐☐☐☐☐☐☐ | Days Supply ☐☐☐

Prescription Number ☐☐☐☐☐☐☐ | Quantity ☐☐☐☐☐ | Drug Name and Strength __________

Pharmacy Name, Address and Phone Number

NABP / NCDPDP/ NPI: ☐☐☐☐☐☐☐☐☐☐

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

I certify that the procedures as indicated by date, have been completed, personally supervised or rendered by me the attending pharmacist, that the fees submitted are actual fees I have charged and intended to collect.

Pharmacist signature: Date:

How To Submit Your Claim

This claim form can be used to submit all your prescription drug receipts. However, a separate claim form must be completed for each person's bills. If you need additional claim forms, please call the EXPRESSLINE at 585-454-5010. If you are calling from outside our area, please call 1-800-548-6428.

If you have any questions about completing the claim form or drug benefits covered under your contract, please call the Customer Service Department number on the back of your identification card.

Mail completed claims to: FLRx
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Rochester, NY 14692

In order to process your claim promptly, please refer to the following guidelines to ensure that all necessary information is included:

A. Submit bills for each patient on separate claim forms. A separate claim form is also required for different calendar years. Please submit the original bills with your claim form. Keep copies for your own records. The actual bills are necessary for claims processing.

B. Bills or receipts must include:

Name and address (on letterhead) of the pharmacy.

Patient's full name.

Date the prescription drug was filled.

Charge for the prescription drug.

National Drug Code (NDC).

Days supply.

Prescription number.

Quantity.

Name of the drug and strength.

Cash register receipts, canceled checks, money orders, credit card vouchers and personal lists of services or bills stating only 'balance forward' are not acceptable as substitutes for bills.

Coordination of Benefits

Your pharmacy receipt should have two charges on it; the original cost of the drug, and the copayment that you paid at the pharmacy. If your pharmacy receipt does not have the original cost, please have the pharmacist complete section four, with the charge being the original cost of the prescription.

Our employees are dedicated to prompt and accurate claim payments to our subscribers. By following these instructions and filling out the claim form completely, you will help us meet our goal of processing your claim in a satisfactory manner.