

Prescription Reimbursement Standard Claim Form

Important!



- * Always allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.
- * Make a copy of all documents submitted and do not staple or tape receipts or attachments to this form. No documents will be returned.

1 Primary Member/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Primary Member Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name (Last Name)

(First Name)

(MI)

Address

City

State

Zip

Patient Information—Use a separate claim form for each patient.

ID No. and Patient Codes will be found on your prescription card.

Name (Last Name)

(First Name)

(MI)

Date of Birth

Male

Female

Relationship to Primary member

Member Spouse Child Other _____

Full-Time College Student

Yes No

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to AdvancePCS, the plan administrator, insurance underwriter, plan sponsor, policyholder and/or employer. I certify that all the information entered on this form is correct.

X

Signature of Primary Member or Legal Representative

Date

2 Prescription Claim Information

NOTE: If you are including all original receipts with the following information, it is not necessary to complete this section. Exception: If submitting compound receipts, this section must be completed. ONLY INCLUDE charges for prescription medications, original receipts and full itemized statements.

Rx	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound				For office use only
	Rx #	Date Filled (m/d/y)	Prescriber's DEA No.					Prior Approval Code
	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	N D C #	Drug Name and Strength		Metric Quantity	Days Supply	Total Charges		

3 Pharmacy Information

NOTE: The pharmacist is to complete this section ONLY if original pharmacy receipts are not included or if there is a compound prescription.

Pharmacy Name

Pharmacy NABP No.

Pharmacy Phone Number

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I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the cardholder.

X

Signature of Pharmacist or Representative

Date

4 Mail This Completed Form To:

Please refer to your prescription card to ensure this form is mailed to the proper address.

IF 610415 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

AdvancePCS
P.O. Box 52116
Phoenix, Arizona 85072-2116

IF 004336 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

AdvancePCS
P.O. Box 853901
Richardson, Texas 75085-3901

Knowingly filing an insurance claim containing materially false information or concealing any material information with the intent to defraud an insurance company or other person is a fraudulent insurance act, which is a crime and subjects one to criminal and civil penalties.