

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 Relationship to Member/Subscriber

<input type="checkbox"/> Female	<input type="checkbox"/> 1 Self	<input type="checkbox"/> 5 Disabled Dependent
<input type="checkbox"/> Male	<input type="checkbox"/> 2 Spouse	<input type="checkbox"/> 6 Dependent Parent
	<input type="checkbox"/> 3 Eligible Child	<input type="checkbox"/> 7 Nonspouse Partner
	<input type="checkbox"/> 4 Dependent Student	<input type="checkbox"/> 8 Other

Pharmacy Information

Name of Pharmacy _____

Street Address _____

City State Zip

Telephone (include area code)

Signature of Pharmacist or Representative (If required by your pharmacy plan) NCPDP#/NPI# (Pharmacy Account Number) (11 Digit Number)

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.

Signature of Member/Subscriber

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 11 digit NDC numbers and ingredients and quantities on the receipt.
- Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____
- Allergy medication** (if covered by your pharmacy plan)

Coordination of Benefits

(Another Health Plan has paid a portion)
Is this a coordination of benefits claim?
 Yes No

If yes, please read Section B on back for details, and mark the appropriate box for your primary coverage method.

- 1 You are submitting an Explanation of Benefits (EOB) from another Health Plan or from Medicare
- 3 You are submitting a copay receipt

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.

