

# 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*

- Female  1 Self  5 Disabled Dependent  
 Male  2 Spouse  6 Dependent Parent  
 3 Eligible Child  7 Nonspouse Partner  
 4 Dependent Student  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.

