Pharmacy Direct Claim / Coordination of Benefits Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

Subscriber Information *See your ID card.*

RxGrp # ☐☐☐☐☐☐☐ *(located under the logo on your ID card)*

Subscriber ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Subscriber Name (First, Last)

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex
- ☐ Female
- ☐ Male

Relation to Plan Subscriber
- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Other
- ☐ 8 Non-Spouse Partner

Pharmacy Information

Name of Pharmacy NABP Number ☐☐☐☐☐☐☐

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐ Yes ☐ No

If yes, I hereby certify that the charge(s) shown for the medications prescribed is (are) correct and agree to provide Medco or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan subscriber and assignment of these benefits to a pharmacy or any other party is void.

X
Signature of Pharmacist or Representative **(Required)**

Claim Receipts

Tape claim receipts or itemized bills on the back. **Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

☐ **is a compound prescription.**
Make sure your pharmacist lists ALL the NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.
ONE CLAIM FORM PER COMPOUND SUBMISSION.

☐ **was purchased outside the U.S.A.**
If so, please indicate:

Country _____

Currency used _____

☐ **is for treatment of an allergy.**

Coordination of Benefits

Is this a coordination of benefits claim?

☐ Yes ☐ No

If "Yes," is this plan ☐ Primary, or ☐ Secondary

If "Secondary," check the primary payment method below. See the back for additional information.

- ☐ 1 Major Medical (attach an Explanation of Benefit from the Primary Insurer)
- ☐ 2 Card Program
- ☐ 3 HMO
- ☐ 4 Mail Order

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. 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.

X
Signature of Subscriber

Claim Receipts

If you have more than two claim receipts or itemized bills to file with this request for reimbursement, tape the additional receipts anywhere on this page. **Do not staple!**

Tape receipt for prescription 1 here

Tape receipt for prescription 2 here

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Pharmacy Information (For Compound Prescriptions ONLY)

- List each NDC number for ALL ingredients used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to the claim form.

RX#: **Date of Service:** **Days Supply:**

NDC#	QTY
TOTAL CHARGE	

When To Use This Form

- Use this form to submit claims for prescription drug benefits. This may include coordination of benefits claims, out of network claims, foreign claims, or compound prescription claims (if your benefit allows for coverage).
- You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
- You must submit claims within one year of date of purchase or as required by your plan.

If You are Coordinating Benefits

Major Medical Plans: You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided above, and attach the Explanation of Benefits from the primary insurance carrier.

Prescription Drug Programs or HMO Plans

Retail Pharmacies: If the primary plan is one in which a copayment or coinsurance is paid at the pharmacy, then no Explanation of Benefits is needed. Just complete this form, and attach the prescription receipt(s) that show the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the Explanation of Benefits.

Mail Order: If the primary plan is mail order, complete this form, and attach either the prescription receipts that show the copayment or coinsurance paid to the mail order pharmacy, or the statement of benefits you receive from the mail order pharmacy.

Instructions

Read carefully before completing this form.

1. **Be sure your receipts are complete.**
   In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
2. The plan subscriber should read the acknowledgement carefully, then sign and date this form.
3. Return the completed form and receipts to:

   Medco
   P.O. Box 2097
   Lee's Summit, MO 64063-7097

For Arizona Residents: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.