## PHARMACY SERVICES PRESCRIPTION DRUG CLAIM FORM

| A. SUBSCRIBER INFORMATION   |                      | FOR OFFICE USE ONLY          |
|---|----------------------|------------------------------|
| ID #  |                      |                              |
|   |                      | Claim #                      |
| Subscriber's Name   |                      |                              |
| (Last)  | (First)              | (MI)                         |
| Street Address  |                      |                              |
| City  | State                | Zip                          |
|   |                      |                              |
| SUBSCRIBER SIGNATURE  |                      |                              |
| B. PATIENT INFORMATION  |                      |                              |
| Patient's Name  |                      |                              |
| (Last)  | (First)              | ` '                          |
| Date of Birth / / Male Female _   | Patients ID          | #                            |
| Patient's relationship to insured: Self Spouse  | _ Dependent          |                              |
|   |                      |                              |
| I certify that all Subscriber and Patient Information is correct and the medication has been dispensed. I   |                      |                              |
| authorize release of any information relating to this claim to GuildNet and all necessary third parties, including  |                      |                              |
| GHI and HIP, for purposes of claims investigation and   | payment, utilizatio  | on review and audit.         |
| DATIENT'S CICNIATUDE.   |                      |                              |
| PATIENT'S SIGNATURE:  |                      |                              |
| C. PHARMACY INFORMATION   | 11                   |                              |
| NABP # Teleph   |                      |                              |
| Pharmacy NamePharmacy Address   | C:4                  | State 7:n                    |
| Pharmacy Address  | City                 | State Zip                    |
| I cortify that the prescription(s) listed below were levelily dispensed for the above named nations information   |                      |                              |
| I certify that the prescription(s) listed below were lawfully dispensed for the above-named patient, information provide is correct and all supporting document is available for audit. |                      |                              |
| provide is correct and an supporting document is available for addit.   |                      |                              |
| PHARMACIST'S SIGNATURE  |                      |                              |
| D1. PRESCRIPTION INFORMATION  |                      |                              |
| Date Dispensed / / Rx #   | New or Refill        | Name of Medication           |
| Dute Dispensed/ RA //   | (Circle One)         |                              |
|   | (                    |                              |
| NDC # Qty Dispensed   | Days Supply          | Strength                     |
| Prescriber's Name   |                      |                              |
|   | P                    | <b>Prescription Cost</b> \$, |
| D2. PRESCRIPTION INFORMATION  | P                    | rescription Cost \$,         |
| Date Dispensed/   | <b>New or Refill</b> | Name of Medication           |
|   | (Circle One)         |                              |
| NDC "   | D 0 1                | G. A                         |
| NDC # Qty Dispensed   |                      |                              |
| Prescriber's Name   | _ Prescriber's Stat  | e License #                  |
| D4 DDECODIDATON DIEODA ( PLON   |                      |                              |
| D3. PRESCRIPTION INFORMATION  | N 15 (*)             | NI CNA P. C.                 |
| Date Dispensed/   |                      | Name of Medication           |
|   | (Circle One)         |                              |
| NDC # Qty Dispensed   | Days Supply          | Strength                     |
| Prescriber's Name:  |                      |                              |
|   |                      | Prescription Cost \$,        |

IMPORTANT: SEE REVERSE FOR INSTRUCTIONS



## INSTRUCTIONS PLEASE PRINT ALL SECTIONS

- 1. This form is to be used to claim prescription drug benefits provided to eligible GuildNet Gold members.
- 2. Please complete all sections. We need all the information requested to process your claims.
- 3. Copy subscriber's/patient's information from your GuildNet Gold Identification Card see sample below.
- 4. Have your pharmacist complete sections C, D1, D2, and D3. Receipts must be attached.
- 5. Use a separate form for each subscriber/patient. In addition, use a separate form for each pharmacy serving the patient.
- 6. Send the form to: GuildNet Gold, P.O. Box 1520 JAF Station, New York, NY 10116-1520.



