PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

A. SUBSCRIBER INFORMATION
ID # _____

FOR OFFICE USE ONLY
Claim # _____

Subscriber's Name _____
(Last) (First) (MI)
Street Address _____
City_____ State_____ Zip_____

SUBSCRIBER SIGNATURE _____

B. PATIENT INFORMATION
Patient's Name _____
(Last) (First) (MI)
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, utilization review and audit.

PATIENT'S SIGNATURE: _____

C. PHARMACY INFORMATION
NABP # _____ Telephone # _____ - _____ - _____
Pharmacy Name _____
Pharmacy Address _____City_____ State_____ Zip_____

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.

PHARMACIST'S SIGNATURE _____

D1. PRESCRIPTION INFORMATION
Date Dispensed ___ /___ / _____ Rx # _____ **New or Refill** (Circle One) Name of Medication _____

NDC # _____ Qty Dispensed _____ Days Supply _____ Strength _____
Prescriber's Name _____ Prescriber's State License # _____
Prescription Cost $ __, __ __ __.__ __

D2. PRESCRIPTION INFORMATION **Prescription Cost** $ __, __ __ __.__ __
Date Dispensed ___ /___ / _____ Rx # _____ **New or Refill** (Circle One) Name of Medication _____

NDC # _____ Qty Dispensed _____ Days Supply _____ Strength _____
Prescriber's Name _____ Prescriber's State License # _____

D3. PRESCRIPTION INFORMATION
Date Dispensed ___ /___ / _____ Rx # _____ **New or Refill** (Circle One) Name of Medication _____

NDC # _____ Qty Dispensed _____ Days Supply _____ Strength _____
Prescriber's Name: _____ Prescriber's State License # _____
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.**