

**PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM**

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| A. SUBSCRIBER INFORMATION ID # _____ | FOR OFFICE USE ONLY Claim # _____ |
| Subscriber's Name _____ (Last) (First) (MI) | |
| Street Address _____ | |
| City _____ State _____ Zip _____ | |
| SUBSCRIBER SIGNATURE _____ | |

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|---|--|
| 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: _____ | |

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| 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 _____ | |

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| D1. PRESCRIPTION INFORMATION Date Dispensed ___ / ___ / ___ Rx # _____ New or Refill Name of Medication _____ (Circle One) | |
| NDC # _____ Qty Dispensed _____ Days Supply _____ Strength _____ | |
| Prescriber's Name _____ Prescriber's State License # _____ | |
| Prescription Cost \$ __, __, __. __ | |

| | |
|--|--|
| D2. PRESCRIPTION INFORMATION Date Dispensed ___ / ___ / ___ Rx # _____ New or Refill Name of Medication _____ (Circle One) | |
| NDC # _____ Qty Dispensed _____ Days Supply _____ Strength _____ | |
| Prescriber's Name _____ Prescriber's State License # _____ | |
| Prescription Cost \$ __, __, __. __ | |

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

MEMBER: JOHN G. SAMPLEPLACEHOLDER
ID NUMBER: 12345678900

Plan: GuildNet Gold Prescription Drug Services
Network: Preferred Pharmacy Network
CAT Code: 0000
Copay: PCP \$0 SPEC \$0 ER \$0 Rx BIN#: 013344
Rx See evidence of coverage. Rx PCN#: 0020080229
No copayment for in-network CIN#: QE11306N
and out-of-network services Issuer#: (80840)
A Medicare Advantage CMS#: H6864001
Prescription Drug+Medicaid Plan

CBP

www.jgb.org/guildnet

For GuildNet Gold Customer Service call toll-free: 1-800-932-4703;
TTY/TDD 1-800-862-1220.
For GHI Medicare GuildNet Provider Service call toll-free: 1-866-557-7300.
For Medicaid GuildNet Provider Service call toll-free: 1-800-932-4703.
For Prescription Drug Services call toll-free: 1-877-444-9973;
TTY/TDD 1-866-248-0640.
Call 911 in an emergency or for medical attention or
as soon as possible. For more information, call 1-800-932-4703.
Submit mail-in claims to: GHI GuildNet, JAF Station, PO Box 1520,
New York, NY 10116.
Submit prescription drug claims to: GHI GuildNet, JAF Station, PO Box 1520,
New York, NY 10116-1520.
Submit Medicaid claims to: GuildNet, PO Box 465148, Lawrenceville, GA 30043

**Certain services may require pre-authorization. Check evidence of coverage.
Medicare limiting charges apply.
Possession of this card does not certify coverage.**

Group Health Incorporated
Union Bug
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