EmblemHealth

# PHARMACY SERVICES
# PRESCRIPTION DRUG CLAIM FORM

## INSTRUCTIONS – PLEASE PRINT ALL SECTIONS

1. This form is to be used to seek reimbursement from EmblemHealth for prescription drug costs you paid above the cost-share amounts outlined under your plan's prescription drug benefits.
2. Complete all sections. We need all the information requested to process your claims.
3. Have your pharmacist complete sections C, D1, D2, and D3. Receipts must be attached.
4. Use a separate form for each subscriber/patient. Use a separate form for each pharmacy serving the patient.
5. Send this form by mail or fax to:

   **Express Scripts:**

   **Attn:** Medicare Part D
   **Address:** P.O. Box 14718
   Lexington, KY 40512-4718
   **Fax Number:** 608-741-5483

6. If you have over-the-counter benefits (which includes coverage for analgesics, proton pump inhibitors, cough/cold medicines, or antacids), attach your itemized receipts and return. You do not need to complete Section C.

   If you have questions, call EmblemHealth at **877-444-7097** (TTY: **711**), 8 am to 8 pm, seven days a week. A representative is happy to help.

| **A. SUBSCRIBER INFORMATION**<br>**ID #** | **FOR OFFICE USE**<br>**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** **Patient's ID #** | **Patient's relationship to insured:**<br>**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 EmblemHealth and all necessary third parties for purposes of claims investigation and payment, utilization review, and audit. | | |
| **PATIENT'S SIGNATURE:** | | |

| C. PHARMACY INFORMATION NABP # | Telephone # | Pharmacy Name |
|---|---|---|
| Pharmacy Street Address | | |
| City | | State ZIP |
| PHARMACIST'S SIGNATURE: | | |

| D1 PRESCRIPTION INFORMATION Date Dispensed | | Name of Medication | | | Rx # |
|---|---|---|---|---|---|
| NDC # | New Refill | Qty Dispensed | Strength | Days Supply | Prescription Cost $__,_____. |
| Prescriber's Name | | | | Prescriber's State License # | |

| D2 PRESCRIPTION INFORMATION Date Dispensed | | Name of Medication | | | Rx # |
|---|---|---|---|---|---|
| NDC # | New Refill | Qty Dispensed | Strength | Days Supply | Prescription Cost $__,_____. |
| Prescriber's Name | | | | Prescriber's State License # | |

| D3 PRESCRIPTION INFORMATION Date Dispensed | | Name of Medication | | | Rx # |
|---|---|---|---|---|---|
| NDC # | New Refill | Qty Dispensed | Strength | Days Supply | Prescription Cost $__,_____. |
| Prescriber's Name | | | | Prescriber's State License # | |

The formulary and pharmacy network may change at any time. You will receive notice when necessary.