Prescription Drug Claim Form

RxPreferred

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses. Please check which reason applies *(at least one must be checked):*

- ☐ Emergency
- ☐ Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier.
- ☐ Eligibility *(Please explain)* _____
- ☐ Non-Participating Pharmacy
- ☐ Compound Prescription (Pharmacist: Please list ALL the VALID 11-digit NDC numbers, ingredients and quantities on the receipt.
- ☐ Other *(Please explain)* _____

PARTICIPANT/PATIENT INFORMATION

Participant Name:	Employer:
ID Number:	Account (Group) Number:
Patient Name *(use a separate form for each family member)*:	Patient Birth Date: *(Mo., Day, Year)*
Participant Mailing Address (will be where payment is mailed)	Participant City, State, Zip
Patient Relationship to Participant:	Patient Sex:
Self (Participant) Spouse Dependent	Male Female

I represent that the patient information entered on this form is correct, that the patient named is eligible for the benefits and that the patient has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees.

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Patient Signature:	**Date:**	**Daytime Phone Number:**

PRESCRIPTION INFORMATION

_____ / _____ / _____ DATE FILLED

_____ RX NUMBER

_____ QTY

_____ DAY SUPPLY

_____ DRUG NAME & STRENGTH

_____ NDC

_____ AMT. PAID

_____ PHARMACY NAME

_____ PHARMACY NABP

Multi-Ingredient Compound Prescription Information - To be Completed by Dispensing Pharmacy.

Pharmacist: Please fill out one form for each multi-ingredient compound prescription. If submitting more than one compound prescription, please copy the form and submit one for each. Thank you.

Information below is required to process multi-ingredient claim submissions. For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, injectables, etc. and the cost. Receipt(s) must be attached to claim form showing prescribing Physician's Name, Address, and DEA #.

#	Quantity	NDC	Drug Name	Charge

INSTRUCTIONS

PARTICIPANT/PATIENT INFORMATION *(To be completed by the Participant)*

1. Complete ALL information on the front side. Claims missing information may be denied, delayed or returned.
2. Sign and date the Certification Statement in the area provided.
3. Complete the RETURN ADDRESS section below.
4. Submit a separate form for each family member.
5. The Prescription Information section must be completed for each prescription for which you are seeking reimbursement. If you need help completing this form, contact your pharmacist. For Health Care Reform related Over-the-Counter reimbursement requests, include your Doctor's prescription. Please retain a copy of the prescription for your records.
6. **Keep a copy for your records.**
7. Mail the claim form within 90 days of the prescription fill date, along with original receipts (cash register receipts are not acceptable), to:

   RxPreferred Benefits
   P.O. Box 396
   Mt. Juliet, TN 37122

8. Questions? Please call RxPreferred at 888.666.7271.