



### Other Insurance Coverage Information

Are you eligible for primary prescription drug coverage from another insurance company?	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	
Other Insurance Company's Name:	
Group Number:	
Member ID Number:	
Effective Date of Coverage:	

### Prescription Information

#	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Drug Name/Strength	Amount Paid	Quantity/Day Supply
1							
2							
3							
4							

### Pharmacy Information

#	Pharmacy Name	Pharmacy Phone Number	Pharmacy NPI Number
1			
2			
3			
4			

### Prescriber Information

#	Prescriber Name	NPI Number	Phone Number	State
1				
2				
3				
4				

**Enrollee Signature**

Notice: Reimbursement for this drug claim is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription drug plan and will be for the amount your program would have paid on your behalf if the prescription drug is covered.

Any person who knowingly and with intent to defraud, injure or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act, which may subject such a person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or the individual for whom I am the Authorized Representative) have received the medicine described herein. I certify that I have read and understood this form, and that all the information included on this form is true and correct.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**REMINDER:**

**To avoid having to submit a paper claim**

- ✓ Always have your prescription drug card at the time of purchase.
- ✓ Always use pharmacies in your network.
- ✓ Use medication covered under your formulary.