UPHP Prescription Drug Claim Form

Instructions for completing UPHP Prescription Drug Claim Form:

Please complete all sections of the claim form below.

- Only one member per claim form.
- Copies of pharmacy receipts and register receipts must be included with submitted claim form.
- The pharmacy receipts must show the following information:

- Pharmacy Name and Address	- Member Name
- Rx Number and Fill Date	- Prescriber Name
- Drug Name, Strength and NDC	- Quantity and Days-Supply
- Drug Cost	- Amount Paid by Member

- Please mail or fax the completed form and accompanying receipts to:

  Magellan Rx Management, LLC
  Attn: CP – 4102
  P.O. Box 64811
  St. Paul, MN 55164-0811

  Fax: 1-800-424-7578

A refund will not be processed until this form and receipts are submitted.

1. Member Name (First, Middle, Last) _____

   Address _____

   City _____ State _____ Zip Code _____
2. Member ID Number _____
3. Birth Date _____

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Magellan Rx Management, its agents, or representatives.

Signature _____ **Date** _____