

Prescription Drug Claim Form/Coordination of Benefits
See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.



Member/Subscriber Information See your member ID card.

Group No. **M M O D R U G**
Member ID

Member Name (First, Last) _____

Street Address _____
City _____ State Zip

Patient Information

Patient Name (First, Last) _____
Patient Date of Birth (Month/Day/Year)

- | | | |
|---------------------------------|--|---|
| Sex | Relation to Plan Member | |
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self | <input type="checkbox"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male | <input type="checkbox"/> 2 Spouse | <input type="checkbox"/> 6 Dependent Parent |
| | <input type="checkbox"/> 3 Eligible Child | <input type="checkbox"/> 7 Other |
| | <input type="checkbox"/> 4 Dependent Student | <input type="checkbox"/> 8 Non-spouse Partner |

Pharmacy Information

Name of Pharmacy _____
Street Address _____
City _____ State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

I hereby certify that the charge(s) shown for the medications prescribed is (are) correct and agree to provide Medco or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the Plan member and assignment of these benefits to a pharmacy or otherwise is void.

X _____
Signature of Pharmacist or Representative (Required) NABP Number Required

Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.

Check the appropriate box if any receipts or bills are for a:

- Compound prescription**
Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and the ingredients and quantities on the receipt or bill.
- Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____
- Allergy medication**

Coordination of Benefits

(Another Health Plan has paid a portion)
Mark the appropriate box for your primary coverage method. See the back for more information.

- 1 Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
- 3 Card Program
- 4 Medco By Mail/mail-order pharmacy

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 is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Please tape receipts on the back.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (and the patient, if not myself) am/are eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I authorize the release of all information to the plan administrator, underwriter, sponsor, policyholder, employer, and their agents for use in connection with the benefit plan programs. This information may also be used for other reporting and analysis purposes without identification of me or my family members. I further authorize the use of my Social Security Number for identification purposes. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of Member

