



Commercial Prescription Drug Claim Form

Claim Form Instructions

Please read carefully before completing this form. **Claim forms that do not include the required information may delay or inhibit our ability to process your request for reimbursement. Completion and submission of this form does not guarantee reimbursement. Claims are subject to limitations, exclusions, and other provisions of your benefit plan.**

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1. The member/cardholder ID Number is located on your insurance card.
2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form. Note: Please do not staple receipts or other documentation to the claim form.
3. For multiple claims, please use the multiple prescription form.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information. Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 123 Any Street Home Town, US 12345-6789	(509)555-1234 Store NPI: 1234567890
RX 1234567	Date Filled: 1/1/2009
DOE, JANE DOB: 01/01/1900 456 Home Road Home Town, US 12345	(509)555-5678
Amoxicillin 500 mg capsules (Teva) 00000-1111-22 QTY: 45	DAW: 0 Days Supply: 30
A. SMITH, MD NPI: 4567890123	
U&C: 200.00	COPAY: 20.00

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

** Denotes information required to process a claim. If this information is not included, it may delay or inhibit our ability to process your request for reimbursement.*

4. Remember to keep a copy of the completed claim form and receipt(s) for your records.
5. Send the completed form and receipt(s) to:

MedImpact Healthcare Systems, Inc.
 PO Box 509098
 San Diego, CA 92150-9108
 Fax: 858-549-1569
 E-mail: Claims@Medimpact.com





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PART 1

*Indicates required information

Primary Subscriber/Cardholder ID Number*		Group Number	
Name of Health Plan/Insurance		Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Member Name: (First, Middle, Last)*		Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>
Primary Subscriber Address: (Street, City, State, Zip code)			
Alternate Address: (Street, City, State, Zip code)			
*If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.			
Member Telephone Number: ()			

Indicate reason for manually filing these claims (select one):

<input type="checkbox"/> Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid and an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
<input type="checkbox"/> Discount Card was used
<input type="checkbox"/> Health plan/insurance information or insurance card not available at the time of purchase
<input type="checkbox"/> Pharmacy not participating in network
<input type="checkbox"/> Pharmacy unable to process claim electronically
<input type="checkbox"/> Emergency – If Emergency, describe emergency below Manual submission of claims does not guarantee reimbursement.

Describe Emergency: _____

PART 2

RX Number	Date Filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength *			Physician Name & NPI Number Name: _____ NPI : _____		RX Price* \$
					Co-Pay* \$

Compound? Yes No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

Pharmacy Name*			Pharmacy Telephone Number		
Street Address			NPI*		
City	State	Zip	Pharmacist Signature*		Date*

I understand that anyone who knowingly or intentionally misrepresents, omits, or falsifies information requested by this form may be found guilty of a crime, and/or subjected to civil or criminal penalties. By signing below, I certify that I have read and understood this form, and that the information provided on this form is true and correct to the best of my knowledge.

Member or Authorized Representative Signature* _____ Date* _____

NOTE: If this form is completed and signed by an Authorized Representative, an Authorization of Representation (AOR) must accompany this form.

