

## Prescription Reimbursement Claim Form

### Important!



- \* Always allow up to 30 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.
- \* Keep a copy of all documents submitted for your records.
- \* Do not staple or tape receipts or attachments to this form.

### STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

#### Card Holder Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name (Last Name)

(First Name)

(MI)

Address

City

State

Zip

#### Patient Information—Use a separate claim form for each patient.

Name (Last Name)

(First Name)

(MI)

Date of Birth

Male

Female

Phone Number

Relationship to Primary member

Member  Spouse  Child  Other \_\_\_\_\_

#### Other Insurance Information

#### **COB (Coordination of Benefits)**

Are any of these medicines being taken for an on-the-job injury?  Yes  No

Is the medicine covered under any other group insurance?  Yes  No

If yes, is other coverage:  Primary  Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_

#### Important! A signature is REQUIRED

#### NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

**X**

Signature of Plan Participant

Date

**STEP 2****Submission Requirements:**

You **MUST** include all original receipts in order for your claim to process. Cash register receipts will only be accepted for diabetic supplies. The minimum information required is:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Days Supply
- Total Charge
- Pharmacy Name and Address or Pharmacy NABP Number

If Foreign Claim: Country: \_\_\_\_\_ Currency: \_\_\_\_\_ Amount: \_\_\_\_\_

**STEP 3****Mailing Instructions:**

NALC Prescription Benefit Program  
P.O. Box 52192  
Phoenix, Arizona 85072-2192

**IMPORTANT REMINDER**

To avoid having to submit a paper claim form:

- Always have your card available at time of purchase
- Always use pharmacies within your network
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card .