

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"/> Male	<input type="checkbox"/> 2 Spouse
	<input type="checkbox"/> 3 Eligible Child
	<input type="checkbox"/> 4 Dependent Student
	<input type="checkbox"/> 5 Disabled Dependent
	<input type="checkbox"/> 6 Dependent Parent
	<input type="checkbox"/> 7 Other
	<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 Health 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.

_____ NABP Number Required

Claim Receipts

Tape claim receipts or itemized bills on the back. **Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

- Is a compound prescription.**
If so, make sure your pharmacist lists all the ingredients and quantities on the receipt.
- Was purchased outside the U.S.A.**
If so, please indicate:
Country _____
Currency used _____
- Is for treatment of an allergy.**

Coordination of Benefits

Is this patient covered under any other insurance plans that cover prescription drugs?

- Yes
- No

If "Yes," Medco Health is

- Primary** Coverage
- Secondary** Coverage

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.

 Signature of Member

Claim Receipts

If you have more than two claim receipts or itemized bills to file with this request for reimbursement, tape the additional receipts anywhere on this page. **Do not staple!**

Tape receipt for prescription 1 here.

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- NABP # (Account number assigned to pharmacy where prescriptions were purchased)
- Doctor name or ID number
- NDC number (Drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written) Indicator (0 = No DAW, 1 = Physician DAW, 2 = Patient DAW, 3 = Pharmacy DAW, 4 = No Generic Available, 5 = Other)
- Amount paid

When To Use This Form

- Use this form to submit direct claims, or to submit claims under the Coordination of Benefit rules.

If you are coordinating benefits

For **major medical** plans, the primary payer's Explanation of Benefits (EOB) must accompany your COB claim form. Failure to attach an EOB may result in the rejection of your claim.

For **prescription drug card** or **HMO** plans where your copayment or coinsurance is paid at the pharmacy, then no Explanation of Benefits is needed. Just complete this form, and attach the prescription receipt(s), which show the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the Explanation of Benefits.

If the primary plan is **mail service**, complete this form, and attach either the prescription receipts which show the copayment or coinsurance paid to the mail service pharmacy, or the statement of benefits you receive from the mail service pharmacy.

Instructions

Read carefully before completing this form

1. **Member ID Number**
Refer to your Medical Mutual of Ohio ID Card.
2. **Be sure your receipts are complete.**
In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
3. The Plan Member should read the Acknowledgement carefully, then sign and date this form.
4. Return the completed form and receipts to:
Medco Health
P.O. Box 2277
Lee's Summit, MO 64063-2277