Prescription Drug Reimbursement Form

Please complete all information.
An incomplete form may delay your reimbursement.

HIGHMARK. West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

medco®

Member/Subscriber Information *See your Member ID card.*

Group No. H M R K 0 0 1

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

☐ Female
☐ Male

Relation to Plan Member

☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Other
☐ 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 any other party is void.

X

Signature of Pharmacist or Representative **(Required)**

NABP Number

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.**
Make sure your pharmacist lists ALL the VALID NDC numbers and quantities for each ingredient on the back of this form and attach receipts. **Claim will be returned if incomplete.**

ONE CLAIM FORM PER COMPOUND SUBMISSION.

☐ **Was purchased outside the U.S.A.**
If so, please indicate:

Country

Currency used

☐ **Is for treatment of an allergy.**

Please tape receipts on the back

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.*

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am 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 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

Claim Receipts

Please tape your receipts here. **Do not staple!**

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- 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)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- 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)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx #		Date filled		Days' supply	

VALID 11-digit NDC #	Quantity	Price
Total quantity		
Total charge		

HOW TO COMPLETE THIS FORM

PLEASE WAIT UNTIL YOU RECEIVE YOUR CURRENT I.D. CARD BEFORE SENDING THIS CLAIM TO MEDCO. CLAIMS WITHOUT THE PROPER IDENTIFICATION NUMBERS FROM YOUR CURRENT ID CARD WILL NOT BE PROCESSED. To avoid undue delay, please complete all required areas of information on the claim form.

Member Information

- Member Number: Copy from your current ID Card.
- Member name, address, and telephone number.
- Patient Name: Person drug was prescribed for.
- Patient Date of Birth: Month, Day, Year.
- Patient Sex: Check Male or Female.
- Status: Patient's relationship to member. If other, please write in type of relationship.
- Use separate claim form for each family member.

* California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

* Pennsylvania: 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 factual material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Pharmacy and Prescription Information

- Pharmacy name and address, where prescription(s) was (were) purchased.
- Tape pharmacy receipts to the form (no staples). Receipts must indicate date of service, prescription number, NDC number, quantity, days' supply and amount paid.
- Receipts must also indicate the dispenser's written indicator: 0=no DAW, 1=physician DAW, 2=patient DAW, 3=pharmacy DAW, 4=no generic available, 5=other.
- Use a separate claim form for each pharmacy from which you purchase prescriptions.

IF THE CLAIM IS FOR A PRESCRIPTION PURCHASED IN A FOREIGN COUNTRY, YOUR RECEIPT, ALONG WITH PRESCRIPTION INFORMATION, SHOULD STATE THE COUNTRY OF PURCHASE AND THE FOREIGN CURRENCY USED.

Any questions?
Call your Member Service number on the back of your ID card.

WHERE TO MAIL THIS FORM

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

CF85835

Visit us on the web at www.mybenefitshome.com