

Prescription Claim Form

Health Plan _____ **Subscriber ID Number: HPF** _____

Subscriber Name _____

(Please print) First Middle Last

Address City State ZIP Code
 Daytime Phone (____) _____ Evening Phone (____) _____

Prescriptions Were Dispensed To:

Patient Name _____
 First Middle Last

Patient Birth Date: _____ Male ___ Female ___

Is this medication for an on-the-job injury? Yes ___ No ___

Is this medication covered under any other group insurance plan? Yes ___ No ___

If yes, please name the insurance company and other employer. _____
 Name of Insurance Company

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Signature of Patient _____

Please attach the duplicate pharmacy generated receipt. If it is unavailable, the pharmacy or dispensing facility must complete the following information. The shaded areas are optional; however, please complete these areas if the information is available.

Rx Number	Date Filled	Check One New ___ Refill ___	Qty	Directions	Days Supply	Rx Price w/Tax
1)						
Medication Name, Form, & Strength			DAW	M.D. DEA#	NDC Number (11 digits)	
2)						
Medication Name, Form, & Strength			DAW	M.D. DEA#	NDC Number (11 digits)	

Note: If the prescription was filled in a foreign country, the currency must be converted into US dollars. The diagnosis and a description of the drug are required for processing.

Pharmacy Name Bedford Pharmacy Pharmacy NABP (Required) 3003023
 Address 209 Route 101, 101 Plaza Pharmacy Phone 603-472-3919
 City Bedford State NH ZIP 03110 Pharmacist's Signature *Ronald L. Petrin*

*Pharmacist's signature required when bottom portion of claim form is completed by pharmacy or dispensing facility only.



10680 Trenea Street 5th floor ■ San Diego, CA 92131

For assistance, please contact our DMR dept at (858) 566-2727.