

Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.



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

Group No. **B N C 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"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male | <input type="checkbox"/> 2 Spouse | <input type="checkbox"/> 6 Dependent Parent |
| | <input type="checkbox"/> 3 Eligible Child | <input type="checkbox"/> 7 Other |
| | <input type="checkbox"/> 4 Dependent Student | <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 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 Required

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

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.**

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.*

Please tape receipts on the back

