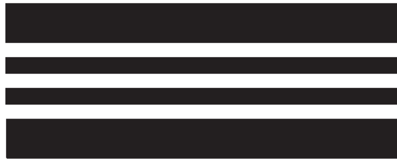
PRESCRIPTION DRUG CLAIM FORM

DO NOT STAPLE IN THIS AREA



☐ Please check this box if you have prescription drug benefits with another insurance carrier and you are coordinating benefits.

Other Insured's Name:____________________________

Other Insured's ID #: ____________________________

Other Insurance Plan Name:________________________

A Cardholder Information:

Cardholder ID #: ____

Name: ____
Last First MI

Address: ____

City:________________________State:__________Zip:____________

B Pharmacy Information:

NCPDP #: ____

Name: ____

Address: ____

City:________________________State:__________Zip:____________

C Prescription was dispensed to:

Patient Name: ____ Patient Birthdate: __ __/__ __/__ __ __ __ Sex: ☐ M ☐ F
Last First MI

Patient Relationship to Cardholder (Check one box) ☐ Cardholder (C) ☐ Spouse (S) ☐ Child (D) ☐ Other Dependent (O)

NOTE: Use a separate claim form for each Prescription Drug Claim.

I certify that the above information is correct and that I have received the drug described below. I also certify that the patient for whom this claim is made is eligible for benefits. The drug listed below is not for treatment of an occupational injury or disease, for which the Employer has accepted liability.

I authorize the pharmacy or physician to furnish the administrator with any information relating to the prescription listed below.

Signature ____

D

YOUR PHARMACIST MUST COMPLETE THIS SECTION – IN ADDITION TO SECTION "B". WE CANNOT PROCESS YOUR CLAIM WITHOUT THIS INFORMATION (INSTRUCTIONS ON REVERSE SIDE OF FORM)

Skip section "D" if you have prescription drug benefits through another insurance carrier (and you are submitting copayments to us). Remember to attach your receipt that contains all information required to process copayment claims.

Date Dispensed	Rx Number	Quantity	Days Supply	NDC Number	Amount Paid
__ __ /__ __ /__ __ __ __					

Medication Name	Physician Name / DEA Number	Is Drug A:
		Compound Rx ☐ Allergy Injection ☐

E Please attach single Prescription Receipt inside the box below

Please <u>tape</u> <u>one</u> receipt in this box

NOTE: Payment for the above claim will be made directly to the covered individual. Any assignment of these benefits is void.

Pharmacist's Signature____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. (Indiana Code IC 27-2-16-3)

Z1006 R9/04

PLEASE RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE

INSTRUCTIONS

Please read this carefully before completing the claim form. Claim forms without the required information will be returned.

PATIENT INSTRUCTIONS

1. Bring the claim form to the pharmacy when you obtain a prescription.
2. Each prescription **must have an original prescription receipt** returned with the claim form. A cash register tape is **not** satisfactory evidence of purchase.
3. A separate claim form must be used for each prescription.
4. If a pharmacy printout is used as the prescription receipt, each prescription line requires a separate claim form.
5. You must complete Sections A, C and E. Your pharmacist must complete Sections B and D.
6. **If you have prescription drug benefits through another insurance carrier (and you are submitting co-payments) the pharmacist does not need to sign the form. Just complete sections A & C and attach your receipt in Section E.**
7. Submit this claim form to Medical Mutual of Ohio®.

PHARMACIST INSTRUCTIONS

1. Please complete all information under Section B and D for each prescription filled.
2. Compound medications will be paid only if **at least one component is a Federal Legend Drug.** The NDC number and name of ingredient must be provided for all Federal Legend Drugs contained in the compound.
3. Each claim form must include the pharmacy name, address and NCPDP Provider I.D. Number.

Enclose your completed claim form (including the original receipt) in an envelope and mail to:

MEDICAL MUTUAL OF OHIO
PO BOX 91487
CLEVELAND OH 44101-3487