Prescription Claim Form

Health Plan _____ Subscriber ID Number _ _ _ _ _ _ _ _ _ _ - - _ _

Subscriber Name _____ _____ _____
(Please print) First Middle Last

_____ _____ _____ _____
Address City State ZIP Code

_____ _____
Daytime Phone (including area code) Evening Phone (including area code)

Prescriptions Were Dispensed To:

Patient Name _____ _____ _____
First Middle Last

Patient Birth Date: _____ Male ___ Female ___ Relationship to Subscriber: Self __ Spouse __ Child __

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, provide the name of the insurance company and other employer. _____
Name of Insurance Company

Note: Use a separate claim form for each covered member of the family.

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 _____
Patient (or Parent if a Minor)

★ **Please attach the duplicate pharmacy generated receipt to this form. If it is unavailable, please have the pharmacy or dispensing facility complete the section below.**

Pharmacy or dispensing facility needs to complete the remaining portion and return this to member. Shaded areas are optional; please complete those areas if information is available.

Rx Number	Date Filled	Check One	Quantity	Directions	Days Supply	Rx Price w/Tax
1)		New___ Refill___				
Medication Name, Form, & Strength		**DAW**	**M.D. DEA#**	**NDC Number (11 digits)**		
Rx Number	**Date Filled**	**Check One**	**Quantity**	**Directions**	**Days Supply**	**Rx Price w/Tax**
2)		New__ Refill__				
Medication Name, Form, & Strength		**DAW**	**M.D. DEA#**	**NDC Number (11 digits)**		
Rx Number	**Date Filled**	**Check One**	**Quantity**	**Directions**	**Days Supply**	**Rx Price w/Tax**
3)		New__ Refill__				
Medication Name, Form, & Strength		**DAW**	**M.D. DEA#**	**NDC Number (11 digits)**		
Rx Number	**Date Filled**	**Check One**	**Quantity**	**Directions**	**Days Supply**	**Rx Price w/Tax**
4)		New__ Refill__				
Medication Name, Form, & Strength		**DAW**	**M.D. DEA#**	**NDC Number (11 digits)**		

Pharmacy Name _____

Address _____

City _____ State _____ ZIP _____

If purchased in a foreign country, the currency must be converted into US dollars. Diagnosis and description of the drug is also required for claim processing.

Pharmacy NABP (Required) _____

Pharmacy Phone _____

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

MedImpact

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For assistance with this form, please contact our DMR department at (858) 566-2727.