

# Prescription Drug Claim Form



## Instructions for completing Prescription Drug Claim Form:

- Complete all sections of the claim form below.
- Submit a completed Universal Compound Form, in addition to this form, for compound reimbursement requests.
- Copies of pharmacy receipts and register receipts must be included with submitted claim form.
- The pharmacy receipts must show the following prescription information for each expense:
  - Pharmacy Name and Address      – Patient Name      – Amount Paid Out-of-Pocket
  - Prescription Number and Fill Date      – Prescriber Name      – Drug Cost
  - Drug Name, Strength, and NDC      – Quantity and Days-Supply
- Mail or fax the completed form and accompanying receipts to:  
**Prime Therapeutics**      **Fax: 1-888-656-3607**  
**Attn: CP – 4102**  
**P.O. Box 64811**  
**St. Paul, MN 55164-0811**
- If you have any questions, please call your Customer Service area.

**Note: This claim will not be processed until this form and accompanying receipts are submitted.**

1. Policyholder or Insured Name (First, Middle, Last): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
2. Policyholder or insured ID No. (as shown on ID Card): \_\_\_\_\_
3. Why was the insurance or drug card not used for this purchase?  
\_\_\_\_\_
4. Patient's Name (First, Middle, Last): \_\_\_\_\_
5. Patient's Birth Date: \_\_\_\_\_
6. Patient's Relationship to Policyholder:  
☐ Self      ☐ Spouse      ☐ Dependent      ☐ Other
7. Is the patient eligible for any other Prescription Drug Coverage?  
☐ No      ☐ Yes      If **yes**, complete the following:  
Does the coverage include:      ☐ Major Medical      ☐ Drug      ☐ Other Medical  
Insured's Name: \_\_\_\_\_ Insured's ID Number: \_\_\_\_\_  
Insured's Birth Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Insurance Company Address (Street, City, State, Zip Code): \_\_\_\_\_  
\_\_\_\_\_

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Prime Therapeutics, its agents, or representatives.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_