



Prescription Drug Claim Form

Each Pharmacy Receipt Must Show:

- ◆ Participant Name
- ◆ Prescription Number
- ◆ Pharmacy Name and Address or NABP Number
- ◆ Name/Strength and NDC Number
- ◆ Metric Quantity/Days Supply
- ◆ Dispense as written (DAW), if applicable
- ◆ Doctor's Name or DEA Number
- ◆ Purchase Date
- ◆ Total Charge

The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

PLEASE COMPLETE SECTIONS 1 THROUGH 4. INCLUDE RECEIPTS BEFORE MAILING.

Please use a separate claim form for each covered member of the family

1. SUBSCRIBER INFORMATION

Primary Cardholder ID# (required)

 Plan/Group ID #

 Plan Sponsor/Employer

 Last Name

 First Name M.I.

 Mailing Address - Street Apt.

 City State Zip Code

 Daytime Phone Number
 - - ext.

2. PARTICIPANT INFORMATION

Participant's Last Name

 Participant's First Name M.I.

 Participant's Birthdate Gender: M F

 Month Day Year Number of Receipts: _____
 Participant's Relationship to Card Holder:
 Self Spouse Daughter Son
 Widowed Full Time Student
 Sponsored Dependent/Other
 Was this prescription obtained while traveling/residing outside the United States? Yes No

3. REASON FOR CLAIM OR SPECIAL NOTES

COB (Coordination of Benefits)
Is the medicine covered under any other group insurance?
 If yes, is other coverage: Primary Secondary
 If other coverage is Primary, include the explanation of benefits (EOB) with this form.
 Name of Insurance Company _____
 ID # _____

4. IMPORTANT! A SIGNATURE IS REQUIRED IN BOTH A AND B

FRAUD PREVENTION REGULATION: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A. _____
Signature of Plan Participant **Date**

RELEASE OF INFORMATION: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury. I have indicated in the COB box above if there is primary prescription drug coverage under another medical plan. I authorize release of all information pertaining to this claim to True Rx, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

B. _____
Signature of Plan Participant **Date**

PLEASE MAIL THIS FORM AND ALL **ORIGINAL PRESCRIPTION RECEIPTS** TO: **True Rx Management Services**
 Attn: CLAIMS
 4 Williams Bros. Drive
 Washington, IN 47501

True Rx Customer Service: 1-866-921-4047