RAdvance
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Prescription Drug Claim Form

Patient Information

<table>
<tr><td>Member ID:</td><td colspan="2">Date of Birth (mm/dd/yyyy):</td></tr>
<tr><td>Patient Name (First, Last):</td><td colspan="2">Patient's Relationship to Primary Subscriber:
Self ☐ Spouse ☐ Dependent ☐</td></tr>
<tr><td colspan="3">Address: (Street, City, State, ZIP)</td></tr>
<tr><td colspan="3">I certify that the information is correct and that the patient indicated above is eligible for benefits.

____
Patient/Subscriber/Member or Legal Representative Signature</td></tr>
<tr><td colspan="3">Is this medication for an on-the-job-injury? ❑ Yes ❑ No</td></tr>
<tr><td rowspan="2">If yes, please provide:</td><td>Name of other insurance:</td><td>Policy Number:</td></tr>
<tr><td colspan="2">Please include any pharmacy receipts related to this claim with this form</td></tr>
</table>

Pharmacy Information

Pharmacy Name:
Pharmacy Address: (Street, City, State, ZIP)

Prescription Claim Information

Please attach original pharmacy receipts to space provided on the back of form. If receipts are not included, please have the pharmacist complete and sign the bottom of this form.	
Was this prescription medication purchased outside the U.S.A.?	❑ Yes ❑ No

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All fields below must be completed. (Example on last page of the form.) Call your pharmacist if you need assistance.		
1	Rx Number:	Date Filled:
	Quantity:	Day Supply:
	Name of Medication:	NDC Number (Your pharmacist can provide the NDC number identifying the drug):
	Physician NPI Number:	Prescription Cost:
	Amount Paid (if any):	
2	Rx Number:	Date Filled:
	Quantity:	Day Supply:
	Name of Medication:	NDC Number (Your pharmacist can provide the NDC number identifying the drug):
	Physician NPI Number:	Prescription Cost:
	Amount Paid (if any):	
3	Rx Number:	Date Filled:
	Quantity:	Day Supply:
	Name of Medication:	NDC Number (Your pharmacist can provide the NDC number identifying the drug):
	Physician NPI Number:	Prescription Cost:
	Amount Paid (if any):	

Pharmacy/Prescription Information

1. Use a separate claim form for each patient.
2. Attach pharmacy receipts in the spaces provided. Be sure that all information on each receipt is readable. Each receipt must show: • Patient Name • Quantity • Pharmacy Name/Address • Fill Date • Total Charge • Rx Number• Drug Name and NDC Number • Days' Supply
If any of your receipts do not have required information, ask your pharmacist to provide you with the missing information. Write that information on your receipt(s). If not completed, the claim will be sent back for the required information.
3. Call the customer service number on your ID card if you have any questions.
4. Have your pharmacist call 800-974-5268 if he/she has any questions.
5. Send completed form to:

RxAdvance Corp
2 Park Central Dr
Southborough, MA 01772

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Example of how to complete the Prescription Drug Claim Form:

1	Rx Number: 000006011761	Date Filled: 07/01/17
	Quantity: 30	Day Supply: 30
	Name of Medication: Lipitor	NDC Number (Your pharmacist can provide the NDC number identifying the drug): 00653456765
	NPI Number: 2222555511	Prescription Cost: 205.14
	Amount Paid (if any): $0.00	

Is this prescription claim for a compound medication? ❑ Yes ❑ No
Note: If yes, make sure your pharmacist completes the information below.

Compound Information:
If this is a compound prescription, please enter all information per drug used.

Compound Prescriptions
For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Pharmacy Receipts Only: Add one pharmacy receipt in this space

Pharmacy Receipts Only: Add one pharmacy receipt in this space