

PRESCRIPTION DRUG CLAIM FORM

Please remember to keep a copy of the completed claim form and receipt(s) for your records.

Send the completed form (all pages) and all receipt(s) to:
ATTN: Consumer Services, RxAdvance, 2 Park Central Drive, Southborough, MA 01772

Note: RxAdvance cannot process incomplete forms. This form must be filled out completely. Incomplete forms will be returned. Manual submission of claims does not guarantee reimbursement. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit as per plan policy and procedures. If you or your pharmacist need assistance or have any questions, please call the number on the back of your Member ID Card.

Pharmacy Claim Form Instructions

PART 1: Member & Subscriber Information

Provide the required member & subscriber information by completing Part 1.

1. Complete all information under Part 1. Subscriber information is located on your Member ID Card.
2. Please submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your Member ID Card.
3. Please submit a separate claim form for each family member and pharmacy from which you have purchased drugs.

IMPORTANT NOTE: Payment & related correspondence will be sent to the subscriber unless you provide us with an Alternate Payment Address in Part 1.

PART 2: Prescription Information

Provide the prescription information by either completing Part 2 or by submitting official pharmacy documents containing the required information with this form. Please ask your pharmacist if you need assistance completing this section. If your prescription is for a compound medication, please ask your pharmacist for a printout of the Compound Drug Information and submit it with the completed form.

Required Prescription Information

- Medication Name & Strength
- National Drug Code (11-digit NDC)
- Prescriber Name
- Date Filled
- Quantity
- Days Supply
- Paid Amount

PART 3: Proof of Payment

Please attach Proof of Payment.

Acceptable Documents Showing Proof of Payment:

- Cashier's receipt you received when paying for your prescription *OR*
- Financial statement you receive from the pharmacy **with a pharmacist's signature**

IMPORTANT NOTE: We are unable to process requests without acceptable Proof of Payment.

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*** Required Information**

PART 1: Member & Subscriber Information

Provide the required information. Subscriber information is located on your Member ID Card.

Subscriber Name*	Subscriber ID #*	Subscriber Date of Birth* (MM/DD/YYYY)
Subscriber Address		
City	State	Zip Code
Member Name*	Member Date of Birth* (MM/DD/YYYY)	Relationship to Subscriber*
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Alternate Payment Address (If different from subscriber address)		
City	State	Zip Code
Member Signature*		Date (MM/DD/YYYY)*

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PART 2: Prescription Information

Provide the required information by either completing the section below or by submitting official pharmacy documents containing the required information with this form. Please ask your pharmacist if you need assistance completing this section.

Required Prescription Information

- Medication Name & Strength
- National Drug Code (11-digit NDC)
- Prescriber Name
- Date Filled
- Quantity
- Days Supply
- Paid Amount

*** Required Information**

Rx#	Medication Name & Strength*	National Drug Code* (11-digit NDC)			<input type="checkbox"/> New <input type="checkbox"/> Refill (Check One)
Prescriber Name*	Date Filled* (MM/DD/YYYY)	Qty*	Days Supply*	Paid Amt*	<input type="checkbox"/> Refill (Check One)

Rx#	Medication Name & Strength*	National Drug Code* (11-digit NDC)			<input type="checkbox"/> New <input type="checkbox"/> Refill (Check One)
Prescriber Name*	Date Filled* (MM/DD/YYYY)	Qty*	Days Supply*	Paid Amt*	<input type="checkbox"/> Refill (Check One)

Rx#	Medication Name & Strength*	National Drug Code* (11-digit NDC)			<input type="checkbox"/> New <input type="checkbox"/> Refill (Check One)
Prescriber Name*	Date Filled* (MM/DD/YYYY)	Qty*	Days Supply*	Paid Amt*	<input type="checkbox"/> Refill (Check One)

Compound Drug Information

Is this prescription claim for a compound medication? Yes No

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If yes, please have your pharmacist provide a printout of the Compound Drug Information and submit it with the completed form.

PART 3: Proof of Payment

Please submit Proof of Payment with this form.

Acceptable Documents Showing Proof of Payment:

- Cashier's receipt you received when paying for your prescription *OR*
- Printed financial statement you receive from the pharmacy ***with a pharmacist's signature***

IMPORTANT NOTE: We are unable to process requests without acceptable Proof of Payment.

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Important Claim Notices

Caution: Any person who knowingly and with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware, Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Indiana: 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.

Maine, Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: 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.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.