

Prescription Drug Claim Form

Important: Please read instructions prior to completing.

- Policyholder or Insured Name (First, Middle, Last) _____
 Address _____
 City _____ State _____ Zip Code _____
- Policyholder or insured ID No. (as shown on ID Card) _____
- Why was the insurance or drug card not used for this purchase? _____
- Employer Name _____
- Patient's Name (First, Middle, Last) _____
- Patient's Birth Date _____
- Patient's Sex Male Female
- Patient's Relationship to Policyholder:
 Self (Male) Self (Female) Husband Wife Son Daughter Other Male Dependent Other Female Dependent
- Is the patient eligible for any other Prescription Drug Coverage? Yes No If yes, complete the following:
 Does the other coverage include: Major Medical Drug Other Medical
 Insured's Name _____ Insured's ID Number _____
 Insured's Birth Date _____ Effective Date _____
 Insurance Company Name _____
 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 Magellan Rx Management, its agents or representatives.

Signature _____ Date _____

Please ask your pharmacist to fill out this section. We cannot process this claim without the following information. Fill out the information below or attach the original receipt to this form. No photocopies will be accepted.

1. Rx Number	Date Filled	Check One <input type="checkbox"/> New Rx <input type="checkbox"/> Refill Rx	Metric Quantity	Days Supply	MD Name	Is Rx No DAW <input type="checkbox"/> 0 MD DAW <input type="checkbox"/> 1 Patient DAW <input type="checkbox"/> 2 RPh DAW <input type="checkbox"/> 3 No Generic <input type="checkbox"/> 4	Rx Price (including tax) \$
	Prescription Date	Number of Refills					
Medication Name, Strength, Dosage Form			Is Drug Compound Rx <input type="checkbox"/>		NDC Number (if compound, include NDCs for all active ingredients)		
2. Rx Number	Date Filled	Check One <input type="checkbox"/> New Rx <input type="checkbox"/> Refill Rx	Metric Quantity	Days Supply	MD Name	Is Rx No DAW <input type="checkbox"/> 0 MD DAW <input type="checkbox"/> 1 Patient DAW <input type="checkbox"/> 2 RPh DAW <input type="checkbox"/> 3 No Generic <input type="checkbox"/> 4	Rx Price (including tax) \$
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	Prescription Date	Number of Refills					
Medication Name, Strength, Dosage Form			Is Drug Compound Rx <input type="checkbox"/>		NDC Number (if compound, include NDCs for all active ingredients)		

If more than 3 prescriptions, please fill out additional claim forms.

Pharmacy Name _____ Phone No. _____ Street _____ City _____ State _____ Zip _____

Provider NPI _____ Pharmacist Signature _____

Note: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of Magellan Rx Management.

Please return completed form to the address shown on reverse side.

Prescription Drug Claim Form

Instructions

Policyholder:

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims that were purchased without using your drug card, or due to an emergency situation.
2. You will be reimbursed directly for all covered services up to the allowed amount.
3. Complete all items of the form for both the patient and policyholder.
4. Sign the form in the area provided.
5. Be sure to include the **original pharmacy receipt**, cash register receipt and this completed form. Please make copies for your own records.
6. Have your pharmacist complete the bottom section of the form.
7. For a list of participating pharmacies in your area, please refer to our website www.magellanrx.com, or call the customer service number on your ID card.
8. Mail completed form to: Magellan Health Services, Attn: Claims Department, 11013 W Broad St, Ste #500, Glen Allen, VA 23060

Pharmacist:

1. Complete all items in the lower portion of this form.
2. Use a separate form for each patient.
3. Be sure to sign the form in the area provided.

If you have any questions, please call Customer Service at 1-800-424-0472.

Insurance Fraud Warning

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 appropriate state agency within the department of regulatory agencies.