

Prescription Advantage Prescription Drug Reimbursement Form RxPCN: **NONMED**
 for members not eligible for Medicare. **Complete both sides of this form.**

Section 1: Member Information				
Last Name		First Name		MI
Mailing Address		City	State	Zip Code
Phone Number ()	Date of Birth ____/____/____	Prescription Advantage ID Number		
Section 2: Pharmacy Information				
Pharmacy Name		Phone Number ()	NCPDP or NABP Number (on receipt or contact pharmacy)	
Address		City	State	Zip Code
Section 3: Signature				
<p>I certify that all information on this claim form is accurate. I understand that Prescription Advantage use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as a medical provider, is in accordance with federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).</p>				
_____		_____		
Member's Signature		Date		
_____		_____		
Authorized Representative's Signature		Date		

After completing both sides, please mail this form and documentation (pharmacy print out) to the following address. For questions, call 1-800-243-4636, or 711 for TTY for the deaf and hard of hearing.

Prescription Advantage
 Attn: Benefit Coordination
 PO Box 15153
 Worcester, MA 01615-0153
 Fax to: 508-421-5622

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 penalties.

Include only prescriptions that may require reimbursement.

Claim 1 (please print)				
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)
Prescriber's Name (Doctor)	Days Supply	Quantity	Form (capsules, cream, etc)	Total Charge \$
Claim 2 (please print)				
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)
Prescriber's Name (Doctor)	Days Supply	Quantity	Form (capsules, cream, etc)	Total Charge \$
Claim 3 (please print)				
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)
Prescriber's Name (Doctor)	Days Supply	Quantity	Form (capsules, cream, etc)	Total Charge \$
Claim 4 (please print)				
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)
Prescriber's Name (Doctor)	Days Supply	Quantity	Form (capsules, cream, etc)	Total Charge \$
Claim 5 (please print)				
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)
Prescriber's Name (Doctor)	Days Supply	Quantity	Form (capsules, cream, etc)	Total Charge \$
Claim 6 (please print)				
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)
Prescriber's Name (Doctor)	Days Supply	Quantity	Form (capsules, cream, etc)	Total Charge \$