

PRESCRIPTION DRUG CLAIM FORM

DO NOT STAPLE IN THIS AREA



Please check this box if you have prescription drug benefits through another insurance carrier and you are submitting copayments to us.

A Cardholder Information:

Cardholder ID #: _____

Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

B Pharmacy Information:

NABP #: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

C Prescription was dispensed to:

Patient Name: _____
Last First MI Patient Birthdate: ____/____/____ Sex: M F

Patient Relationship to Cardholder (Check one box) Cardholder (C) Spouse (S) Child (D) Other Dependent (O)

NOTE: Use a separate claim form for each Prescription Drug Claim.

I certify that the above information is correct and that I have received the drug described below. I also certify that the patient for whom this claim is made is eligible for benefits. The drug listed below is not for treatment of an occupational injury or disease, for which the Employer has accepted liability. I authorize the pharmacy or physician to furnish the administrator with any information relating to the prescription listed below.

Signature _____

D YOUR PHARMACIST MUST COMPLETE THIS SECTION - IN ADDITION TO SECTION "B". WE CANNOT PROCESS YOUR CLAIM WITHOUT THIS INFORMATION (INSTRUCTIONS ON REVERSE SIDE OF FORM)

Skip section "D" if you have prescription drug benefits through another insurance carrier (and you are submitting copayments to us). Remember to attach your receipt that contains all information required to process copayment claims.

Date Dispensed ____/____/____	Rx Number	Quantity	Days Supply	NDC Number	Amount Paid
Medication Name			Physician Name / DEA Number		Is Drug A: Compound Rx <input type="checkbox"/> Allergy Injection <input type="checkbox"/>

E Please attach single Prescription Receipt inside the box below

Please tape one receipt in this box

NOTE: Payment for the above claim will be made directly to the covered individual. Any assignment of these benefits is void.

Pharmacist's Signature _____

WARNING: 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. (Ohio Revised Code Section 3999.21)

WARNING: 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. (Indiana Code IC 27-2-16-3)

Z1006 R12/02 **PLEASE RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE**

INSTRUCTIONS

Please read this carefully before completing the claim form. Claim forms without the required information will be returned.

PATIENT INSTRUCTIONS

1. Bring the claim form to the pharmacy when you obtain a prescription.
2. Each prescription **must have an original prescription receipt** returned with the claim form. A cash register tape is **not** satisfactory evidence of purchase.
3. A separate claim form must be used for each prescription.
4. You must complete Sections A, C and E. Your pharmacist must complete Sections B and D.
5. **If you have prescription drug benefits through another insurance carrier (and you are submitting co-payments) the pharmacist does not need to sign the form. Just complete sections A & C and attach your receipt in Section E.**
6. Submit this claim form to Medical Mutual.

PHARMACIST INSTRUCTIONS

1. Please complete all information under Section B and D for each prescription filled.
2. Claims for syringes will be paid only if dispensed on the same prescription with insulin. **Consecutive Rx numbers should be used for insulin and syringes.**
3. Compound medications will be paid only if **at least one component is a Federal Legend Drug**. The NDC number that should be used for compounds is 99999-9999-99. The "Medication Name" box should itemize all Federal Legend Drugs contained in the compound.
4. Each claim form must include the pharmacy name, address and NABP I.D. Number.

**Enclose your completed claim form (including the original receipt)
in an envelope and mail to:**

**MEDICAL MUTUAL
PO BOX 91487
CLEVELAND OH 44101-3487**