Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

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Member/Subscriber Information *See your prescription drug ID card.*

Group no. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member name (first, last)

Street address

City State ☐☐ Zip ☐☐☐☐☐

Patient Information

Patient name (first, last)

Patient date of birth (month/day/year) ☐☐ ☐☐ ☐☐☐☐

Sex
☐ Female
☐ Male

Relation to plan member
☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible child
☐ 4 Dependent student
☐ 5 Disabled dependent
☐ 6 Dependent parent
☐ 7 Other
☐ 8 Nonspouse partner

Pharmacy Information

Name of pharmacy

Street address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

Claim Receipts

Tape claim receipts or itemized bills on the back.
Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

☐ **Is a compound prescription.**
If so, make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and ingredients and quantities on the receipt.

☐ **Was purchased outside the United States.**
If so, please indicate:
Country _____
Currency used _____

☐ **Is for treatment of an allergy.**

Coordination of Benefits

(Another health plan has paid a portion.)
Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?
☐ Yes ☐ No

☐ 1 Another health plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid.
☐ 3 Card program
☐ 4 **Medco By Mail**/mail-order pharmacy

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury. I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of member

Claim Receipts

If you have more than two claim receipts or itemized bills to file with this request for reimbursement, tape the additional receipts anywhere on this page. **Do not staple!**

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength

Tape receipt for prescription 2 here.

- Quantity and days' supply
- Prescription number (Rx number)
- DAW (dispense as written)
- Amount paid

PHARMACY INFORMATION (for Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx no.		Date filled		Days' supply	

VALID 11-digit NDC no.	Quantity
Total quantity	
Total charge	

When to Use This Form

- Use this form to submit claims under coordination of benefit rules.
- You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
- You must submit claims within 1 year of date of purchase or as required by your plan.

Another health plan paid

You must first submit the claim to the primary insurance carrier. Once the statement from the primary plan has been received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided above, and attach a statement from the primary plan that clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription drug program or HMO plans

Retail pharmacies: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no explanation of benefits is needed. Just complete this form and attach the prescription receipt(s) that show the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the explanation of benefits.

Medco By Mail/mail-order pharmacy: If the primary plan is Medco By Mail, complete this form and attach either the prescription receipts that show the co-payment or coinsurance amount paid to the mail-order pharmacy, or the statement of benefits you receive from the mail-order pharmacy.

Instructions

Read carefully before completing this form

1. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
2. The plan member should read the acknowledgment carefully, then sign and date this form.
3. Return the completed form and receipt(s) to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.

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