## **Prescription Drug Claim Form**



Your clean and complete claim will be processed within 14 days of receipt of your request. Please allow additional mail time.

Policyholder Information (Reference your member ID drug card.)  Additional Claim Information		
Member ID: Group Number:	Check all applicable boxes and ensure claim specific section	
Plan or Employer Name:	below is complete.	
First Name: Middle Initial:	Standard Prescription Complete page 1 and Claims Receipts section on page 2.	
Address:	Compound Prescription	
City: State: Zip Code:	COVID-19 At-Home Test Kit (No Medicaid or Medicare)	
Date of Birth:	Medicare Out-of- Network Purchase	
<b>Patient Information:</b> (If different than the policyholder)	Medicare Part D Vaccine	
First Name: Middle Initial:		
Last Name: Patient Date of Birth:		
Relationship to Policyholder: Spouse Child Other Dependent		
Pharmacy Information		
Pharmacy Name:		
Street Address: City:		
State: Zip Code: Pharmacy NPI:		
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 Capital Rx. Any assignment of these benefits must include an appropriate signature and is subject to Capital Rx's approval.		
Signature Dat	to.	
Patient or Authorized Representative		
Please note: If you are preparing this form on behalf of a member, please include a completed Personal Health Information Disclosure Form. For Medicare Part D members, please include a completed CMS-1696 form (Appointment of Representative form) or Personal Health Information Disclosure Form. Per CMS regulations, a purported representative may submit a completed CMS-1696 form or a form that includes the same information as the CMS-1696 form. Blank forms are available by visiting <a href="https://www.cap-rx.com/members#member-forms">https://www.cap-rx.com/members#member-forms</a> .		

## Compound Prescriptions Only List the valid 11-digit NDC number for each ingredient used Prescription Rx Day for the compound prescription. Number: Fill Date: Supply: For each NDC number, indicate the metric quantity in the Valid 11-digit Ingredient NDC: **Ingredient Cost** Quantity number of tablets, grams, milliliters, creams, ointments, injectables, etc. For each NDC number, indicate cost per ingredient. Include the total charge paid by the patient. (dollar amount) **Total Quantity** Receipts must be included with Total Charge the completed claim form. **COVID-19 At-home Test Kits Only** Number of Tests in Kit: Kit Name: Purchase Date: Include the image of the COVID-19 At-Home Test Kit package with a visible barcode. Include register receipts with the date of purchase. Multiple line items on your receipt? Please circle or highlight the COVID-19 At-Home Test Kit line item for ease of processing. Medicare Only: Out-of-Network Purchase Please check the reason that best applies to your situation. Were any prescriptions filled because of: Illness after traveling outside of the service area? Yes No Medication not in stock at No network pharmacy within No Yes Yes No my network pharmacy? reasonable driving distance? Federal emergency/ Vaccine received at Yes No Yes No natural disaster? my doctor's office? **Medicare Only: Part D Vaccine Claim** Rx Number: (if applicable) Date Filled: Vaccine Name: **NPI Number:** Total Paid for Administrative Fee: Total Paid for Vaccine: Vaccine NDC Number: Prescribing Physician: Prescribing Physician Address: 'Circle' Administered Location: Physician Office Clinic Pharmac Is this a 2-part vaccine?: (i.e., Shingrix)

**Claim Receipts:** Attach the original register receipt(s) and prescription information included with your prescription bag to this completed claim form. Please refer to the COVID-19 At-home Test Kit section for receipt requirements.

If yes, is this shot:

Register receipts or prescription information must include the following information. Please list the amount paid on the line provided.

- Prescription fill/purchase date
- Pharmacy name and address
- Prescriber name and prescriber NPI
- National Drug Code (NDC)

No

Yes

Drug name, strength, and dosage form

Second part in a series

- Prescription number (Rx number)
- Dispense as Written (DAW)

First part in a series

Amount Paid \$

## Prescription Drug Claim Form Instructions



Please read carefully before completing the form.

1	Always present your member ID card at the participating retail pharmacy.
2	Use this form when you have paid full price for a prescription drug at a retail pharmacy.
3	You must complete a separate claim form for each pharmacy and patient.
4	You must submit within one (1) year of the date of service or as required by your plan. For Medicare Only: Claims must be submitted within 36 months from the date of service.
5	For your request to be processed, all receipts must contain the information listed within this form. Your pharmacist can provide the necessary information if your claim or bill is not itemized. Please note that a cash register receipt is not sufficient.  For Medicare Only: Completion of the Prescription Drug Claim form is recommended but not required. You may submit equivalent written documentation, but it must provide all the requested information on this form. Please note that missing, incomplete, or hard-to-read documentation can delay the successful processing of your claim.
6	Incomplete forms may be returned or delay the process.
7	Please make copies of all documents for your records.
8	Reimbursement of submitted claims is subject to your prescription benefit program and is not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and will be for the amount your program would have paid on your behalf. The reimbursement amount may be significantly lower than the original amount you paid. Please remember that completing this form is not a reimbursement guarantee.

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.