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ATTN: CLAIMS DEPT
MedImpact Healthcare Systems, Inc. 10680 Treena Street 5th floor San Diego, CA 92131
Fax to: (858) 549-1569

PRESCRIPTION DRUG CLAIM FORM

In order to process your claim(s), you must provide all information requested below. Submit the completed form with the original pharmacy prescription label/receipt(s). Documents provided, other than original pharmacy receipts (i.e., prescription profiles) must be signed by the pharmacist and include the following information: NDC, quantity, day supply, Rx # and fill date, DEA#, NABP, and amount member paid).

Primary Member/Cardholder Information

Primary Member/Cardholder ID Number	Primary Member/Cardholder Name (First, Middle, Last)		
Name of Health Plan/Insurance	Member Phone Number (Day) ( ) -	Member Phone Number (Evening) ( ) -	
Address (Street)	(City)	(State)	(Zip Code)

Patient Information (if different than Primary Member's/Cardholder's)

Patient's Name (First, Middle, Last)	Patient's DOB (MM/DD/YYYY)	Relationship to Primary Member/Cardholder: Spouse ☐ Dependent ☐ Other ☐	
Address (Street)	(City)	(State)	(Zip Code)

Other Coverage Information

Covered under any other insurance? Coordination of Benefits (COB) ☐ If COB, please indicate the name of primary insurance here: ______	Is Medicare the Primary Prescription Coverage? Yes ☐ No ☐	Worker's Compensation? ☐ If Worker's Compensation is selected, please **stop** and submit claim to your employer.

*Submit either **prescription receipts/labels** with the following information – and/or have your **pharmacist** sign and complete the Prescription Details.

Prescription Details

- Pharmacy Name/Address
- Prescription Number & Date Filled
- Physician's Name or DEA #
- Drug Name & Strength or NDC #
- Quantity and Day Supply Dispensed
- Member Paid Expense

1) Rx Number	Date Filled	Check One: New ☐ Refill ☐	Quantity	Day Supply	Directions	Total Price w/Tax $
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $

2) Rx Number	Date Filled	Check One: New ☐ Refill ☐	Quantity	Day Supply	Directions	Total Price w/Tax $
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $

3) Rx Number	Date Filled	Check One: New ☐ Refill ☐	Quantity	Day Supply	Directions	Total Price w/Tax $
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Yes ☐ No ☐
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $

Pharmacy Information

Pharmacy Name			Pharmacy Telephone Number	
Street Address			NABP	
City	State	Zip	Pharmacy Signature	Date

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Claimant Signature **X**

Warning it is a crime to provide false information or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any persons knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.