

Prescription Drug Claim Form



Instructions for completing Prescription Drug Claim Form:

- Complete all sections of the claim form below.
- Submit a completed Universal Compound Form, in addition to this form, for compound reimbursement requests.
- Copies of pharmacy receipts and register receipts must be included with submitted claim form.
- The pharmacy receipts must show the following prescription information for each expense:
 - Pharmacy Name and Address – Patient Name – Amount Paid Out-of-Pocket
 - Prescription Number and Fill Date – Prescriber Name – Drug Cost
 - Drug Name, Strength, and NDC – Quantity and Days-Supply
- Mail or fax the completed form and accompanying receipts to:
Prime Therapeutics **Fax: 1-888-656-3607**
Attn: CP – 4102
P.O. Box 64811
St. Paul, MN 55164-0811
- If you have any questions, please call your Customer Service area.

Note: This claim will not be processed until this form and accompanying receipts are submitted.

1. Policyholder or Insured Name (First, Middle, Last): _____
Address: _____
City: _____ State: _____ Zip Code: _____
2. Policyholder or insured ID No. (as shown on ID Card): _____
3. Why was the insurance or drug card not used for this purchase?

4. Patient's Name (First, Middle, Last): _____
5. Patient's Birth Date: _____
6. Patient's Relationship to Policyholder:
☐ Self ☐ Spouse ☐ Dependent ☐ Other
7. Is the patient eligible for any other Prescription Drug Coverage?
☐ No ☐ Yes If **yes**, complete the following:
Does the coverage include: ☐ Major Medical ☐ Drug ☐ Other Medical
Insured's Name: _____ Insured's ID Number: _____
Insured's Birth Date: _____ Effective Date: _____
Insurance Company Name: _____
Insurance Company Address (Street, City, State, Zip Code): _____

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 Prime Therapeutics, its agents, or representatives.

Signature: _____ **Date:** _____