Prescription Drug Claim Form

Prime THERAPEUTICS™

Member information (See other side for instructions)

ID number

Date of birth / / ❑ Male ❑ Female

Name (First, Last)

Street address

City State Zip

Member's relationship to primary cardholder:

❑ Self ❑ Spouse/Domestic partner ❑ Dependent/Child

I certify that:

- The information on this form is correct.
- The member named above is eligible for pharmacy benefits.
- The member named above received the medicine(s) listed.
- These benefits have not been assigned; any further assignment is void.
- I give my permission to share the information on this form with Prime Therapeutics LLC.

X

Member or legal representative signature

Is this medicine for an on-the-job injury? ❑ Yes ❑ No

Do you have other insurance for this prescription medicine? ❑ Yes ❑ No

If yes, what is the other insurance company's name?

Cardholder information (primary cardholder)

Name (First, Last)

Why are you submitting this Prescription Drug Claim Form? (check one)

☐ Did not have my pharmacy card with me when I bought this prescription

☐ Have not received my pharmacy card

☐ Picked up my medicine from a non-network pharmacy

☐ My other insurance is paying for part of this medicine (attach that company's Explanation of Benefits and an itemized receipt)

☐ Other (please explain)

*If your plan has elected to cover COVID-19 home test kits, please use this form to be reimbursed. There is a limit of eight at-home rapid tests per 30 days.

If your plan covers prescribed at-home, urine-based pregnancy test kits, please use this form to be reimbursed. There is a limit of two at-home pregnancy tests per 30 days.

For COVID-19 or pregnancy at-home test kits, please attach the itemized pharmacy receipt(s) and submit to the address on the back of this form. Cash register receipts will **not** be accepted.

Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

X

Pharmacist signature

Pharmacy NPI number

Prescription (Rx) claim information*

Was this prescription medicine purchased outside the United States? . . . . . ❑ Yes ❑ No

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach itemized pharmacy receipts to the back of this form.

Claims are subject to your plan's limits, exclusions and provisions.

1

Rx number

Date filled / /

Quantity Days' supply

Name of medicine

NDC number

(Your pharmacist can provide the national drug code [NDC] and national provider identifier [NPI] numbers.)

Physician NPI number

Prescription cost $.

Balance due $.

2

Rx number

Date filled / /

Quantity Days' supply

Name of medicine

NDC number

(Your pharmacist can provide the national drug code [NDC] and national provider identifier [NPI] numbers.)

Physician NPI number

Prescription cost $.

Balance due $.

Instructions

1. Use a separate claim form for each member and prescription. All information provided on or attached to this claim form must be for the same person/prescription.
2. Attach the original itemized pharmacy receipt(s) provided with your prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: Your claim will be sent back if required information is missing.

Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Prescription cost
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

3. Send this completed form with itemized receipt(s) to:

   Prime Therapeutics Commercial
   PO Box 20690
   Lehigh Valley, PA 18002-0690

Questions?
You can call the number on the back of your member ID card.

EXAMPLE

Rx number 0 0 0 0 0 6 0 1 1 4 8 1

Date filled 0 1 / 1 2 / 2 3

Quantity 30 Days' supply 3 0

Name of medicine "Drug Name"

NDC number 0 0 1 2 3 4 5 6 7 3 1

(Your pharmacist can provide the national drug code [NDC] and national provider identifier [NPI] numbers.)

Physician NPI number 0 1 2 3 4 5 6 7 8 9

Prescription cost $ 2 0 5 . 1 4

Balance due $ 2 0 5 . 1 4

Is this prescription claim for a compound medicine?
❑ Yes ❑ No

Note: If yes, ask your pharmacist to complete the information below.

Compound information

Please enter all information for each drug used.

Compound prescriptions

For pharmacy use only

NDC number	Drug ingredient	Quantity	Charge

Rx receipts

Attach original itemized pharmacy receipts here.

All required information must be visible (see instructions above).

Keep a copy of this form and your receipt(s) for your records.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any health plan or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent health plan act, which is a crime and subjects such person to criminal and civil penalties.

Prime Therapeutics LLC is an independent company that provides pharmacy solutions for UFCW members.