ProCare Rx

PRESCRIPTION DRUG CLAIM FORM

Today's Date: _____/_____/_____

When complete, return claim form to:
ProCare Rx Claims Reimbursement
1267 Professional Parkway
Gainesville, GA 30507

A. Insured/Patient Information

Cardholder Last Name	First Name	Middle Initial	Plan Name	Cardholder ID #

Address	City	State	Zip

Home Phone ( )	Work Phone ( )	Employer Name	Group #

Employer Address	City	State	Zip

Do you or any other member of your family have additional group insurance which may cover all or part of this claim?

Primary Coverage? YES ☐ NO ☐ Secondary Coverage? YES ☐ NO ☐

If YES, provide the Insurance Name and Group #:

Patient Last Name	First Name	Middle Initial	Relationship to Cardholder
			Self ☐ Dependent ☐ Spouse ☐ Other ☐

Mailing Address (Patient's address if payment should be mailed to a different address than Cardholder's Address)

City	State	Zip	Date of Birth	Patient's Sex
				Male: ☐ Female ☐

B. Claim Information

Pharmacy ID #	Pharmacy Name	Fill Date _____/_____/_____	Rx #	Metric Quantity
Days Supplied	NDC #	Prescriber		Charge
Pharmacy ID #	Pharmacy Name	Fill Date _____/_____/_____	Rx #	Metric Quantity
Days Supplied	NDC #	Prescriber		Charge
Pharmacy ID #	Pharmacy Name	Fill Date _____/_____/_____	Rx #	Metric Quantity
Days Supplied	NDC #	Prescriber		Charge
Pharmacy ID #	Pharmacy Name	Fill Date _____/_____/_____	Rx #	Metric Quantity
Days Supplied	NDC #	Prescriber		Charge

C. Reason for Claim Submission or Special Notes

D. Authorization

I certify that the above information is true and correct to the best of my knowledge and hereby authorize any physician, pharmacy, employer, union, insurance company or HMO to supply any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

X_____ _____

Insured's Signature Date Signed

Prescription Drug Claim Form

INSTRUCTIONS

Please read the following instructions carefully and fill out reverse side of this form.

SECTION A – INSURED/PATIENT INFORMATION (Complete this section for each family member who has received medication.)

1. Print Today's Date
2. Print Cardholder's name (last, first, middle initial)
3. Print Cardholder's plan name and identification number (found on prescription drug or health insurance card)
4. Print Cardholder's address information and telephone numbers
5. Print Employer name, group number and Employer address information (found on prescription drug or health insurance card)
6. Indicate if covered under another drug plan, include the insurance company name and group number
7. Print Patient's name (last, first, middle initial) and indicate Relationship to Cardholder
8. Print mailing address (patient's address, if payment should be mailed to a different address than the Cardholder's address above)
9. Patient's Date of Birth and Patient's Sex

SECTION B – CLAIM INFORMATION

Submit either prescription receipts/labels with this claim form or a patient history printout from your pharmacy. It is preferable to have them unattached. Please do not staple, tape or glue.

Claims received missing any of the following information may be returned or payment may be denied.

- **Pharmacy ID #** – 7-digit pharmacy identifier (NABP #)
- **Pharmacy Name** – Pharmacy name
- **Fill Date** – Date drug was dispensed
- **Rx Number** – Prescription number
- **Metric Quantity** – Quantity of the drug dispensed
- **Days Supplied** – The number of days supplied of the drug dispensed
- **NDC #** – 11-digit drug code
- **Prescriber** – Prescribing physician's name
- **Charge** – Amount paid for the prescription

Note: Altered receipts require pharmacist's signature.

SECTION C – REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES

This section can be used for special notes or comments

SECTION D – AUTHORIZATION

Insured's Signature and Date signed

IMPORTANT: Claim form must be signed. (Unsigned claim forms cannot be processed and will be returned.)

QUESTIONS? Call ProCare Rx Customer Service Department at 800-699-3542.

Please return this claim to:

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1267 Professional Parkway
Gainesville, GA 30507