AmeriHealth

AmeriHealth Insurance Company of New Jersey
QCC Insurance Company d/b/a AmeriHealth Insurance Company
AmeriHealth HMO, Inc.

13477
Rev. 07/06

Prescription Reimbursement Claim Form

Part 1 Cardholder/ Patient Information

Part 1 must be fully completed to ensure proper reimbursement of your drug claim.

Please type or print clearly.

Cardholder ID No. _____ RX PCN O3820000 _____

Cardholder Name _____ Address _____

City _____ State _____ ZIP _____ Phone ( ) _____

Patient Information — Use a separate claim form for each family member

Patient Name _____ Date of Birth _____

Patient: ❍ Male ❍ Female Relationship: ❍ Member ❍ Spouse ❍ Child ❍ Other _____

Are any of these medications being taken for an on-the -job injury? ❍ Yes ❍ No

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for prescription benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to FutureScripts, the prescription benefit manager or its processing subcontractor; insurance underwriter; plan sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

x _____

Signature of Cardholder or Legal Representative **Date**

Part 2 Important

Please remember to include all original pharmacy receipts.

Original receipts must be included with the following information. **NOTE:** Do not staple or tape receipts or attachments to this form.

- Member Name
- Date of Purchase
- Metric Quantity/Days supply
- Prescription Number
- Total Charge
- Drug Name
- Drug Strength or NDC Number
- Pharmacy Name and Address or NABP Number

Part 3 Pharmacy Information

Pharmacist to complete this section ONLY if compound prescription

- To ensure that your patient receives accurate and timely reimbursement for medication purchases, please assist in completing the information below. Please enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescriptions section on the reverse side.

Pharmacy Name _____ Pharmacy NABP No. _____

Pharmacy Address _____ City _____

State _____ ZIP _____ Phone ( ) _____

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the cardholder.

x _____

Signature of Pharmacist or Representative **Date**

Rx 1	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound			For office use only Prior Approval Code
	NDC #		Drug Name and Strength		Metric Quantity	Days Supply	Total Charges
Rx 2	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound			For office use only Prior Approval Code
	NDC #		Drug Name and Strength		Metric Quantity	Days Supply	Total Charges
Rx 3	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound			For office use only Prior Approval Code
	NDC #		Drug Name and Strength		Metric Quantity	Days Supply	Total Charges

INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each patient
- Each pharmacy from which you purchase prescription drugs

CLAIM SUBMISSION

When submitting a claim, the following information must be included:

- Member Name
- Prescription Number
- Date of Purchase
- Drug Name
- Total Charge
- Pharmacy Name and Address or NABP Number
- Drug Strength/NDC Number
- Metric Quantity/Days Supply
- Original Pharmacy Receipts

DO NOT submit canceled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

HOW TO COMPLETE THIS FORM

Cardholder/ Patient Information

Complete all cardholder and patient information in Part 1 on reverse side.

- The cardholder ID number can be found on your ID card.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to FutureScripts. No documents will be returned.

PHARMACY INFORMATION

Pharmacist to complete Part 3 of the form

- Indicate pharmacy name, NABP number, address and phone number.
- Include Rx number(s), drug name(s), strength(s) and date filled.
- Indicate prescriber's DEA number and whether the prescription is new, refill, DAW or compound.
- Include NDC number(s) for the drug(s) dispensed.
- Enter the NDC number of the most expensive ingredient of the legend drug used in the compound.
- Indicate the drug ingredient(s) and quantity.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables.
- Indicate the "days supply" (the number of days the medication will last).
- Indicate the dollar amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call 1-888-678-7012.

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC #	Drug Ingredient	Quantity	Charge

MAIL THIS FORM TO:

FUTURE SCRIPTS™

FutureScripts
Dept. #0382
PO Box 419019
Kansas City, MO 64141

If you have any questions, please call 1-888-678-7012.

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