

MEMBER CLAIM FORM

1. Instructions for completing this form are on the reverse side. All information in each section must be provided. **Incomplete information will result in payment delays and returned forms.**
2. **All Member Claim forms must be accompanied by an original Pharmacy receipt that includes the drug name, the RX number, the Doctor's name and the cost of the prescription.**
3. A separate form must be completed for each Member and for each Pharmacy utilized.
4. If you need assistance completing this form, please contact Customer Service at 1-800-771-4648.

Please Type or Print Clearly

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">A</td> <td>CARDHOLDER INFORMATION</td> </tr> <tr> <td colspan="2">Cardholder ID No. _____ Group No. _____</td> </tr> <tr> <td colspan="2">Cardholder Name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First </div> </td> </tr> <tr> <td colspan="2">Address: _____</td> </tr> <tr> <td colspan="2">City: _____ State: _____ Zip: _____</td> </tr> <tr> <td colspan="2">Daytime Phone: (____) _____</td> </tr> </table>	A	CARDHOLDER INFORMATION	Cardholder ID No. _____ Group No. _____		Cardholder Name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First </div>		Address: _____		City: _____ State: _____ Zip: _____		Daytime Phone: (____) _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">B</td> <td>PHARMACY INFORMATION</td> </tr> <tr> <td colspan="2">NABP Number: _____</td> </tr> <tr> <td colspan="2">OR</td> </tr> <tr> <td colspan="2">Pharmacy Name: _____</td> </tr> <tr> <td colspan="2">Address: _____</td> </tr> <tr> <td colspan="2">City: _____ State: _____ Zip: _____</td> </tr> <tr> <td colspan="2">Phone: (____) _____</td> </tr> </table>	B	PHARMACY INFORMATION	NABP Number: _____		OR		Pharmacy Name: _____		Address: _____		City: _____ State: _____ Zip: _____		Phone: (____) _____	
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C	MEMBER INFORMATION
Member Name: _____ Date of Birth: _____ Sex: <input type="radio"/> M <input type="radio"/> F	
Member Address (if different from Cardholder): Street or P.O. Box: _____ City: _____ State: _____ Zip: _____	
What is the Member's relationship to the Cardholder? <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent	
Does the Member have other prescription drug coverage? <input type="radio"/> Yes <input type="radio"/> No	
If yes, please provide the name of other coverage: _____	
Did the Member submit this claim to the other coverage? <input type="radio"/> Yes <input type="radio"/> No Amount they reimbursed you? _____	
Did the Member use a Network Pharmacy? <input type="radio"/> Yes <input type="radio"/> No If NO, give a reason:	
<input type="radio"/> Drug not available at Network Pharmacy <input type="radio"/> Prescription needed while on vacation <input type="radio"/> Emergency <input type="radio"/> Other (please explain): _____	

D	PRESCRIPTION INFORMATION											
Date Rx Filled	Prescription Number	National Drug Code (NDC)						Qty.	Days Supply	New/or Refill	DAW Y/N	Amt. Paid
		Drug Name & Strength										

By signing below, I certify that the above information is correct. I authorize MedTrak Services to send reimbursement and Rx information to the Cardholder, unless otherwise indicated below.

MEMBER SIGNATURE: _____
(May be signed by Cardholder only if member is legal dependent of Cardholder.)

PRINT NAME: _____

Check this box if reimbursement and Rx information should be sent to Member.

MAIL COMPLETED FORM TO: **MedTrak Services**
6310 Lamar, Suite 230
Overland Park, KS 66202

INTERNAL USE ONLY CLAIM NUMBER

MEMBER CLAIM FORM

INSTRUCTIONS FOR COMPLETING FORM: All information must be provided in order to accurately process your claim(s).

A CARDHOLDER INFORMATION

Cardholder ID No. Enter the Cardholder Identification Number, which is printed on the front of your enrollment card.

Group Number Enter the Group Number as printed on the front of your enrollment card, or enter the Name of the Employer.

Cardholder Name This information is applicable to the Cardholder.

Address

City, State, Zip

Daytime Phone (optional) Enter the telephone number of the Cardholder. It may be needed if we have any questions regarding the claim.

B PHARMACY INFORMATION

NABP Number Enter the NABP number, which is assigned to the Pharmacy by the National Association of Boards of Pharmacy. This is available from your Pharmacist.

Pharmacy Name If you do not know the Pharmacy's NABP number, include the Pharmacy's name, street address, city, state, and zip code. **A separate form is required for each Pharmacy utilized.**

Address

City, State, Zip

Phone Number Enter the Pharmacy's phone number, including area code.

C MEMBER INFORMATION (Please complete *all* information in this section.)

All information in this section applies to the Member for whom the prescription(s) was/were dispensed. **A separate form is required for each Member.**

D PRESCRIPTION INFORMATION

The information needed for this section can be found on the prescription receipt, or it is available from your pharmacist.

Date Rx (Prescription) Filled Enter the date the prescription was filled.

Prescription Number Enter the number assigned to the prescription by the Pharmacy.

National Drug Code (NDC) Enter the National Drug Code, which identifies the drug product dispensed.

Drug Name & Strength Enter the name of the drug and the strength (e.g., Zantac 150 mg).

Quantity (Qty.) Enter the number of tablets/capsules or the quantity of the medication dispensed. Liquids, such as cough medicine, or vials, such as insulin, can come in quantities of milliliters (ml) or ounces (oz). Creams or ointments can come in quantities of grams (gm).

Days' Supply Enter the number of days for which the medication was prescribed (e.g., 30 days). (A medicine taken twice a day, with a quantity of 60 tablets, would provide a 30 day supply).

New or Refill Enter N for a new prescription or R for a refill.

DAW (Dispense As Written) Did the doctor require the drug to be dispensed as written (DAW)? Enter Y for yes. If not, and therefore generic substitution was permitted, enter N for No.

Amt. Paid Enter the amount that you paid the Pharmacy for the prescription.

NOTE: The reimbursement and Rx information to be sent may contain personal and sensitive information related to the Member's health care. By signing this form, the signer agrees to ensure the security, integrity and confidentiality of this information. If you have any questions regarding this form, please call 1-800-771-4648