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

A CARDHOLDER INFORMATION

Cardholder ID No. _____Group No._____

Cardholder Name: _____
Last First

Address: _____

City: _____ State:_____ Zip:_____

Daytime Phone: (____)_____

B PHARMACY INFORMATION

NABP Number: _____
OR
Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: (____)_____

C MEMBER INFORMATION

Member Name: _____ Date of Birth: _____ Sex: O M O F

Member Address (if different from Cardholder): Street or P.O. Box: _____

City: _____ State: _____ Zip: _____

What is the Member's relationship to the Cardholder? O Self O Spouse O Dependent

Does the Member have other prescription drug coverage? O Yes O No

If yes, please provide the name of other coverage. _____

Did the Member submit this claim to the other coverage? O Yes O No Amount they reimbursed you?_____

Did the Member use a Network Pharmacy? O Yes O No **If NO, give a reason:**

O Drug not available at Network Pharmacy
O Prescription needed while on vacation
O Emergency
O Other (please explain): _____

D PRESCRIPTION INFORMATION

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

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 **Address** **City, State, Zip**	This information is applicable to the Cardholder.
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 **Address** **City, State, Zip**	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.**
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