



PHARMACY SERVICES PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS – PLEASE PRINT ALL SECTIONS

1. This form is to be used to seek reimbursement from EmblemHealth for prescription drug costs you paid above the cost-share amounts outlined under your plan’s prescription drug benefits.
2. Complete all sections. We need all the information requested to process your claims.
3. Have your pharmacist complete sections C, D1, D2, and D3. Receipts must be attached.
4. Use a separate form for each subscriber/patient. Use a separate form for each pharmacy serving the patient.
5. Send this form by mail or fax to:

For EmblemHealth Medicare HMO and PPO

Attn: Pharmacy Services
Address: PO Box 1520 JAF Station
 New York, NY 10116-1520
Fax Number: 646-583-9686

6. If you have over-the-counter benefits (which includes coverage for analgesics, proton pump inhibitors, cough/cold medicines, or antacids), attach your itemized receipts and return. You do not need to complete Section C.

If you have questions, please call us at **877-444-7097** (TTY: **711**), seven days a week, 8 a.m. to 8 p.m. A representative is happy to help.

A. SUBSCRIBER INFORMATION	FOR OFFICE USE
ID #	Claim #
Subscriber’s Name (Last) (First) (MI)	
Street Address	
City	State ZIP
SUBSCRIBER SIGNATURE:	

B. PATIENT INFORMATION

Patient’s Name (Last) (First) (MI)

Date of Birth ___/___/___	Male Female	Patient’s ID #	Patient’s relationship to insured: Self Spouse Dependent
I certify that all Subscriber and Patient Information is correct and the medication has been dispensed. I authorize release of any information relating to this claim to EmblemHealth and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.			
PATIENT’S SIGNATURE:			

C. PHARMACY INFORMATION NABP #		Telephone #		Pharmacy Name	
Pharmacy Street Address					
City				State	ZIP
PHARMACIST'S SIGNATURE:					
D1 PRESCRIPTION INFORMATION Date Dispensed		Name of Medication			Rx #
NDC #	New	Refill	Qty Dispensed	Strength	Days Supply
					Prescription Cost \$_____.
Prescriber's Name				Prescriber's State License #	
D2 PRESCRIPTION INFORMATION Date Dispensed		Name of Medication			Rx #
NDC #	New	Refill	Qty Dispensed	Strength	Days Supply
					Prescription Cost \$_____.
Prescriber's Name				Prescriber's State License #	
D3 PRESCRIPTION INFORMATION Date Dispensed		Name of Medication			Rx #
NDC #	New	Refill	Qty Dispensed	Strength	Days Supply
					Prescription Cost \$_____.
Prescriber's Name				Prescriber's State License #	

The formulary and pharmacy network may change at any time. You will receive notice when necessary.

HIP Health Plan of New York (HIP) is a HMO plan and Group Health Incorporated (GHI) is a PPO plan with a Medicare contract. Enrollment in HIP and GHI depends on contract renewal. HIP and GHI are EmblemHealth companies.