



PHARMACY SERVICES PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS – PLEASE PRINT ALL SECTIONS

1. This form is to be used to seek reimbursement from ConnectiCare for prescription drug costs you paid above the cost-share amounts outlined under your plan’s prescription drug benefits.
2. Complete all sections of this form. We need all the information requested to process your claims.
3. Have your pharmacist complete sections C, D1, D2, and D3. All prescription receipts must be attached.
4. Refer to your ConnectiCare Medicare member ID card for the member information requested.
5. Use a separate form for each subscriber/patient.
6. Send this form and receipts to:

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

If you have questions, call Member Services at **800-224-2273** (TTY: **711**). Our hours are 8 a.m. to 8 p.m., seven days a week. A representative is happy to help.

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

B. PATIENT INFORMATION

Patient's Name (Last) (First) (MI)			
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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 ConnectiCare 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.