Coordination of Benefits Form/Direct Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

Member/Subscriber Information *See your prescription ID card.*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City   State ☐☐   Zip ☐☐☐☐☐

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex
- ☐ Female
- ☐ Male

Relation to Plan Member
- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Other
- ☐ 8 Non-spouse Partner

Pharmacy Information

Name of Pharmacy

Street Address

City   State ☐☐   Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

I hereby certify that the charge(s) shown for the medications prescribed is/are correct and agree to provide Medco Health or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Pharmacist or Representative
(Required)

NABP Number Required

Claim Receipts

Tape claim receipts or itemized bills on the back.
Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

- ☐ **Is a compound prescription.**
  If so, make sure your pharmacist lists ALL the ingredients and quantities on the receipt.
- ☐ **Was purchased outside the U.S.A.**
  If so, please indicate:
  Country ______
  Currency used ______
- ☐ **Is for treatment of an allergy.**

Coordination of Benefits

Is this a coordination of benefits claim?

☐ Yes   ☐ No

If "Yes," is this plan ☐ Primary, or
☐ Secondary

If "Secondary," check the primary payment method below. See the back for additional information.

- ☐ 1 Major Medical (attach an Explanation of Benefit from the Primary Insurer)
- ☐ 2 Card Program
- ☐ 3 HMO
- ☐ 4 Home Delivery/Mail Service

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member

CF901220 3-04

Claim Receipts

If you have more than two claim receipts or itemized bills to file with this request for reimbursement, tape the additional receipts anywhere on this page. **Do not staple!**

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

When To Use This Form

- Use this form to submit claims under Coordination of Benefit Rules.
- You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
- You must submit claims within one year of date of purchase or as required by your plan.

Major Medical Plans

You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided above, and attach the Explanation of Benefits from the primary insurance carrier.

Prescription Drug Programs or HMO Plans

Retail Pharmacies: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no Explanation of Benefits is needed. Just complete this form, and attach the prescription receipt(s) that show the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the Explanation of Benefits.

Home Delivery/Mail Service: If the primary plan is home delivery/mail service, complete this form, and attach either the prescription receipts that show the co-payment or coinsurance paid to the home delivery/mail service pharmacy, or the statement of benefits you receive from the home delivery/mail service pharmacy.

Visit us on the Web at **www.medcohealth.com**.

Instructions

Read carefully before completing this form

1. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
2. The plan member should read the acknowledgement carefully, then sign and date this form.
3. Return the completed form and receipt(s) to:

   Medco Health
   P.O. Box 2277
   Lee's Summit, MO 64063-2277