

EBRx PRESCRIPTION DRUG CLAIM FORM

EMPLOYER NAME _____

GROUP NUMBER _____

SOCIAL SECURITY NUMBER of employee, retiree, or surviving spouse.

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EMPLOYEE INFORMATION:

Please follow instructions as you and the Pharmacist complete this form. **YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETED CORRECTLY.**

Name (Print) _____
 First Middle Last

Mailing Address _____
 Street City State Zip

NOTE: Use a separate claim form for each covered member of the family.

PATIENT INFORMATION:

Name (Print) _____
 First Middle Last

Patient Birthdate / /
 MO DA YR

Sex: F M
 Circle One

Patient Relationship (Check One Box)
 SELF SPOUSE CHILD

I certify that the above information is correct and that I have received the drugs described below. I also certify that the patient for whom this claim is made is eligible for benefits. The drugs listed below are not for treatment of an occupational injury or disease, for which the Employer has accepted liability. The medication is not covered under any other group insurance plan or other employer.

THIS FORM MUST BE SIGNED: SIGNATURE _____ DATE _____

PRESCRIPTION INFORMATION: YOUR PHARMACIST MUST COMPLETE THIS SECTION: WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION

CLAIM NUMBER 1	Rx NUMBER	DATE Rx FILLED M / D / Y	<input type="checkbox"/> NEW <input type="checkbox"/> REFILL	NO DAW MD NAW PATIENT DAW RPH DAW NO GENERIC BRAND DISP/ GENERIC-PRICE	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)	Compound Yes No
B <input type="checkbox"/>	NATIONAL DRUG CODE		METRIC QTY. DISPENSED	DAYS SUPPLY		NAME OF PRESCRIBING PHYSICIAN OF I.D. NO.	PREScription PRICE Including All Discounts
G <input type="checkbox"/>	LABEL BRAND	PRODUCT NO.	PKG.				\$

CLAIM NUMBER 2	Rx NUMBER	DATE Rx RILLED M / D / Y	<input type="checkbox"/> NEW <input type="checkbox"/> REFILL	NO DAW MD NAW PATIENT DAW RPH DAW NO GENERIC BRAND DISP/ GENERIC-PRICE	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)	Compound Yes No
B <input type="checkbox"/>	NATIONAL DRUG CODE		METRIC QTY. DISPENSED	DAYS SUPPLY		NAME OF PRESCRIBING PHYSICIAN OF I.D. NO.	PREScription PRICE Including All Discounts
G <input type="checkbox"/>	LABEL BRAND	PRODUCT NO.	PKG.				\$

CLAIM NUMBER 3	Rx NUMBER	DATE Rx RILLED M / D / Y	<input type="checkbox"/> NEW <input type="checkbox"/> REFILL	NO DAW MD NAW PATIENT DAW RPH DAW NO GENERIC BRAND DISP/ GENERIC-PRICE	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)	Compound Yes No
B <input type="checkbox"/>	NATIONAL DRUG CODE		METRIC QTY. DISPENSED	DAYS SUPPLY		NAME OF PRESCRIBING PHYSICIAN OF I.D. NO.	PREScription PRICE Including All Discounts
G <input type="checkbox"/>	LABEL BRAND	PRODUCT NO.	PKG.				\$

CLAIM NUMBER 4	Rx NUMBER	DATE Rx RILLED M / D / Y	<input type="checkbox"/> NEW <input type="checkbox"/> REFILL	NO DAW MD NAW PATIENT DAW RPH DAW NO GENERIC BRAND DISP/ GENERIC-PRICE	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)	Compound Yes No
B <input type="checkbox"/>	NATIONAL DRUG CODE		METRIC QTY. DISPENSED	DAYS SUPPLY		NAME OF PRESCRIBING PHYSICIAN OF I.D. NO.	PREScription PRICE Including All Discounts
G <input type="checkbox"/>	LABEL BRAND	PRODUCT NO.	PKG.				\$

 PHARMACY NAME / DISPENSING PHYSICIAN

 PHARMACY NABP NUMBER

IF DISPENSED BY PHYSICIAN USE ALL (SPACES FOR TIN NUMBER

 STREET ADDRESS

CITY STATE ZIP

I certify the charge(s) shown for the drugs specified.

THIS FORM MUST BE SIGNED: SIGNATURE _____ **Date** _____
 Pharmacist / Dispensing Physician

PHONE #

ENROLLEE: PLEASE RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE.

INSTRUCTIONS

A. WHEN TO USE THIS FORM

Use this claim form for reimbursement for prescription drug purchases at retail pharmacies.

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form. Enter the employee's social security number and group number.
2. A Separate claim form must be completed for each patient.
3. Have your Pharmacist complete the Prescription and Pharmacy information for each prescription filled.

IMPORTANT: The drug quantity, drug name and strength or National Drug Code is required and **MUST** appear on the submitted claim(s).

4. **FOR COMPOUNDED PRESCRIPTIONS ONLY** — If your pharmacist tells you this is a compounded prescription, you must complete this area below. Ask your pharmacist for assistance. Should you have more than two compounded prescriptions, please use additional claim forms.
5. The original **PAID** pharmacy receipt(s) must accompany this form. A cash register receipt is not sufficient evidence of purchase.

CLAIM NO.	COMPOUND INGREDIENTS			CLAIM NO.	COMPOUND INGREDIENTS		
	DRUG NAMES	QTY	COST		DRUG NAMES	QTY	COST

6. **Claim forms submitted without the required information will cause payment delay or may be returned.**

C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to:

EBRx, Inc.
P.O. Box 25427
Pittsburgh, PA 15220
2. Please allow six to eight weeks for processing and payment of your claims.
3. If you have any questions concerning your submitted claim, please contact EBRx, Inc. at 1-800-800-7153 during regular business hours.