

**DIRECTIONS:**

1. Complete and sign claim form below. Use a separate form for each patient.
2. Attach Explanation of Benefits (if applicable) and Prescription Receipts.
3. Send completed Form & Pharmacy receipts to:  
**PRIME THERAPEUTICS, LLC; P.O. Box 25136; Lehigh Valley, PA 18002-5136**

## I. POLICY HOLDER INFORMATION

POLICY HOLDER NAME (LAST, FIRST, MIDDLE)		MEMBER ID NUMBER <b>H</b>	DATE OF BIRTH (MM/DD/YYYY)
GROUP NUMBER			
STREET ADDRESS			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY, STATE, ZIP CODE			

## II. PATIENT INFORMATION (Must be completed if patient is a dependent child or spouse.)

PATIENT NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH (MM/DD/YYYY)	
ADDRESS (If different than member)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> DISABLED DEPENDENT CHILD
CITY, STATE, ZIP CODE			

## III. GENERAL INFORMATION

**A.** Was condition related to an accident?  YES  NO Accident Date (MM/DD/YYYY) \_\_\_\_\_  
If yes, was it related to:  Auto Accident  Workers' Comp  Other \_\_\_\_\_

**B.** Is other insurance applicable to charge?  YES  NO  
If yes, complete the information below. You must submit an Explanation of Benefits (EOB) for your claim to be processed.  
Other Carrier Name \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Amount Paid By Other Insurance \$ \_\_\_\_\_

## IV. PHARMACY INFORMATION

The Pharmacy NCPDP number can be found on the pharmacy receipt, or may be obtained from the pharmacy.

PHARMACY NAME	NCPDP #	NPI #	PHONE
STREET ADDRESS		CITY, STATE, ZIP CODE	
PHARMACIST SIGNATURE		PHARMACIST LICENSE NUMBER	

## V. PRESCRIPTION INFORMATION

**Prescription receipts are required for processing. Cash register receipts are not acceptable. Ensure each receipt shows the information below. Ask your pharmacist to provide any missing information. A pharmacy patient history may be submitted in lieu of a receipt, but must be signed by the pharmacist.**

- Patient Name
- Pharmacy Name and Address
- Drug Name and NDC#
- Fill Date
- Prescription Number
- Total Charge
- Days Supply
- Quantity
- Doctor Name and DEA#
- DAW (Dispense as Written Code)

## VI. CERTIFICATION

I certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, or files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

POLICY HOLDER/PATIENT SIGNATURE	DATE
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**Reason for mailing in claim:**  System not available at pharmacy  My information not on file at pharmacy  Non-participating pharmacy  
 Pharmacy would not submit claim  I had not received my Florida Blue card yet  Extension of benefits  MediScript  
 Primary coverage is with another carrier (Attach Explanation of Benefits from primary carrier)  Other \_\_\_\_\_