





## INSTRUCTIONS

### A. WHEN TO USE THIS FORM

This claim form is to be used for all prescriptions if your plan requires you to first pay for the prescription and provides that your reimbursement benefit will be provided under your major medical/comprehensive coverage.

For other plans, this claim form is to be used only when it has been necessary to purchase a prescription because no participating pharmacy was available to fill your prescription while you were out of town.

Submit this form as soon as you have your prescription(s) filled in order to receive prompt payment. It **IS NOT** necessary to retain the form until you have filled in five prescription claims.

### B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under **EMPLOYEE** information. Transfer the **employee identification number and group number** from your identification card or prescription drug enrollment application.
2. A separate claim form must be completed for each **patient**.
3. Have your pharmacist complete the **PRESCRIPTION** information for each prescription filled and the **PHARMACY** information. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or receipt.

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

4. The original **paid** pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory evidence of purchase.
5. **–FOR COMPOUND PRESCRIPTIONS ONLY–**If only 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.

| Claim # | Drug Names | Qty | Cost |
|---------|------------|-----|------|
|         |            |     |      |

| Claim # | Drug Names | Qty | Cost |
|---------|------------|-----|------|
|         |            |     |      |

6. Claim forms submitted without the required information and/or employee signature will cause payment delays and will be returned.

### C. WHERE TO SUBMIT THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to:  
**MemberHealth, Inc.**  
P O Box 391180  
Cleveland, OH 44139
2. Please allow six to eight weeks for processing and payment of your claims.
3. You may call 888-868-5854 for questions or problems concerning your submitted claims.