



# PHARMACY BENEFIT SERVICES PRESCRIPTION DRUG CLAIM FORM

FOR OFFICE USE ONLY			
Claim Number			
A. SUBSCRIBER INFORMATION			
ID #		Claim #	
Subscriber's Name (Last)		(First)	(MI)
Street Address			
City		State	ZIP
SUBSCRIBER'S SIGNATURE _____			
B. PATIENT INFORMATION			
Patient's Name (Last)		(First)	(MI)
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's ID #	
Patient's relationship to insured/subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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 EmblemHealth and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.			
PATIENT'S SIGNATURE _____			
C. PHARMACY INFORMATION			
NABP/NPI #		Telephone #	
Pharmacy Name			
Pharmacy Address			
City		State	ZIP
PHARMACIST'S SIGNATURE _____			
D1. PRESCRIPTION INFORMATION			
Date Dispensed	Rx #	<input type="checkbox"/> New <input type="checkbox"/> Refill	Name of Medication
NDC #	Qty Dispensed	Days Supply	Strength
Prescriber's Name		Prescriber's State License #	Prescription Cost \$ _____
D2. PRESCRIPTION INFORMATION			
Date Dispensed	Rx #	<input type="checkbox"/> New <input type="checkbox"/> Refill	Name of Medication
NDC #	Qty Dispensed	Days Supply	Strength
Prescriber's Name		Prescriber's State License #	Prescription Cost \$ _____

**IMPORTANT: SEE REVERSE FOR INSTRUCTIONS**

## INSTRUCTIONS

### PLEASE PRINT ALL SECTIONS

1. This form is to be used to claim prescription drug benefits provided to eligible EmblemHealth subscribers.
2. EmblemHealth subscribers, please complete sections A and B. We need all the information requested to process your claims.
3. Copy subscriber's/patient information from your EmblemHealth Identification Card.
4. Have your pharmacist complete sections C, D1 and D2. Receipts must be attached.
5. Use a separate form for each patient. In addition, use a separate form for each pharmacy serving the patient.
6. Send the form to: **EmblemHealth Pharmacy Benefit Services, 55 Water Street, New York, NY 10041.**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**