EmblemHealth®

PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS – PLEASE PRINT ALL SECTIONS

1. This form is to be used to claim prescription drug benefits provided to eligible EmblemHealth Medicare HMO or EmblemHealth Medicare PPO and EmblemHealth Medicare PDP subscribers.
2. Please complete all sections. We need all the information requested to process your claims.
3. Have your pharmacist complete sections C, D1, D2, and D3. Receipts must be attached.
4. Use a separate form for each subscriber/patient. In addition, use a separate form for each pharmacy serving the patient.
5. Send the form and receipts to:

For EmblemHealth Medicare PPO:
PO Box 1520 JAF Station
New York, NY 10116-1520.

For EmblemHealth Medicare HMO:
PO Box 1520 JAF Station
New York, NY 10116-1520

For EmblemHealth Medicare PDP:
PO Box 1520 JAF Station
New York, NY 10116-1520

6. If you have OTC benefits (which includes coverage for analgesics, proton pump inhibitors, cough/cold medicines or antacids) please attach your itemized receipts and return. You do not need to complete Section C.

A. SUBSCRIBER INFORMATION		FOR OFFICE USE
ID #		Claim #
Subscriber's Name (Last) (First) (MI)		
Street Address		
City	State	ZIP
SUBSCRIBER SIGNATURE		

B. PATIENT INFORMATION			
Patient's Name (Last) (First) (MI)			
Date of Birth ___ / ___ /_____	☐ Male ☐ Female	Patients ID #	Patient's relationship to insured: ☐ Self ☐ Spouse ☐ 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 Medicare HMO/PPO/PDP, and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.			
PATIENT'S SIGNATURE:			

Please see next page.

C. PHARMACY INFORMATION

NABP #	Telephone # _____ - _____ - _____	Pharmacy Name
Pharmacy Street Address		
City	State	ZIP
I certify that the prescription(s) listed below were lawfully dispensed for the above-named patient, information provided is correct and all supporting documents are available for audit.		
PHARMACIST'S SIGNATURE		

D1. PRESCRIPTION INFORMATION

Date Dispensed _____ /_____ / _____		Name of Medication			Rx #
NDC #	☐ New ☐ Refill	Qty Dispensed	Strength	Days Supply	Prescription Cost $ __, __ __ __.__ __
Prescriber's Name				Prescriber's State License #	

D2. PRESCRIPTION INFORMATION

Date Dispensed _____ /_____ / _____		Name of Medication			Rx #
NDC #	☐ New ☐ Refill	Qty Dispensed	Strength	Days Supply	Prescription Cost $ __, __ __ __.__ __
Prescriber's Name				Prescriber's State License #	

D3. PRESCRIPTION INFORMATION

Date Dispensed _____ /_____ / _____		Name of Medication			Rx #
NDC #	☐ New ☐ Refill	Qty Dispensed	Strength	Days Supply	Prescription Cost $ __, __ __ __.__ __
Prescriber's Name				Prescriber's State License #	

Group Health Incorporated (GHI) is a PPO plan and a standalone PDP with a Medicare contract. HIP Health Plan of New York (HIP) is an HMO plan with a Medicare contract. Enrollment in GHI and HIP depends on contract renewal. GHI and HIP are EmblemHealth companies.