CountyCare Prescription Drug Claim Form

Claim Form Instructions

Please read carefully before completing this form. Claim forms without the required information cannot be processed and will be returned to sender.

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1.
2. Submit receipts for reimbursement within 60 days of when they were filled.
3. Submit a separate claim form for each member and pharmacy from which you purchased medications.

Part 2: Receipt

1. Submit prescription receipts/labels that contain the requested information (shown below) OR have your pharmacist complete Part 2 and Part 3. Note: If you do not have a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a blank page with the claim form.
3. For multiple claims, please submit a separate Part 2 for each medication.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information.

Anytime Pharmacy #1234 (509)555-1234
123 Any Street **(12) Store NPI: 1234567890**
Hometown, US 12345-6789

(2) RX 1234567 **(1) Date Filled: 1/1/2009**

DOE, JANE DOB:
01/01/1900
456 Home Road (509)555-5678
Hometown, US 12345

(6) Amoxicillin 500 mg capsules (Teva) **(9) DAW: 0**
(5) 00000-1111-22 **(3) QTY: 45**
(4) Day Supply: 30

(7) A. SMITH, MD **(8) NPI: 4567890123**

(10) U&C: 200.00 **(11) COPAY: 20.00**

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

**REQUIRED INFORMATION - CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED.*

Part 3: No Receipt (To be completed by the pharmacy)

1. If required information is not available, ask your Pharmacist to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records.

Part 4: Send the completed form and receipt(s) to:

MedImpact Healthcare Systems, Inc.

PO Box 509098
San Diego, CA 92150-9098
Fax: 858-549-1569/E-mail: Claims@Medimpact.com

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PART 1 *Indicates required information

Member/Cardholder ID Number*	Group Number	
Name of Health Plan/Insurance	Relationship to Member: Self ☐ Authorized Representative ☐	DOB: (mm/dd/yyyy)* / /
Member Name: (First, Middle, Last)*		
Primary Address: (Street, City, State, Zip code)		
Alternate Address: (Street, City, State, Zip code) ***If no alternate address is specified, communications and/or payment will be forwarded to the address on file with your health plan/insurance.**		
Member Signature*	Telephone Number ( )	Date

Indicate reason for manually filing these claims (select one):

- ☐ Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
- ☐ Health plan/insurance information or insurance card not available at the time of purchase
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency – If Emergency, describe emergency below

Manual submission of claims does not guarantee reimbursement.

Describe Emergency: ____

PART 2

RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength *			Physician Name & NPI Number Name:____________________ NPI : ____________________	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled * / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength *			Physician Name & NPI Number Name:____________________ NPI : ____________________	RX Price* $	Co-Pay* $

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			NPI*	
City	State	Zip	Pharmacist Signature*	Date*

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IMPORTANT CLAIM NOTICE

AL, AK, AZ, CT, DE, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OR, RI, SC, SD, VT, WI, WY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties. **Additionally, DE, ID, MN, NM, OH Residents**: Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or criminal penalties.

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