CLAIM FORM INSTRUCTIONS

Please read carefully before completing this form. **Claim forms without the require**

located on yourinsurance card.

2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt Information

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form. Not

N/PHARMACY INFORMATIO N

Pre scription Label Example: Please use this example as a guide to locate the required information.
Note: Each pharmacy may have a unique label format.

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

RX 1234567 **Date Filled: 1/1/2009**

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

Amoxicillin 500 mg capsules (Teva) **DAW: 0**
00000-1111-22 **QTP**

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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: Pharmacy Information (To be completed by the pharmacy)

1. If required information is not available on the receipt, 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.
3. 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

PART 1

***Indicates required information**

Primary Member/Cardholder ID Number*	Group Number	
Name of Health Plan/Insurance	Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /

Patient Name: (First

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