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Prescription Drug Claim Form

When Completed Return To:
FairScript LLC
Attn: Claims Reimbursement
7914 W. Dodge Road, No. 378
Omaha, NE 68114
Phone: (866) 878-8479

A.– Insured / Patient Information:

Cardholder's Last Name First Name Middle Initial	Plan Name:	Cardholder ID:	Today'sDate: / /
Cardholder's Address, City, State, Zip Code:			
Telephone: ( ) - ☐ Home ☐ Mobile/Cell	Alternate Telephone: ( ) - ☐ Work ☐ Other:_____		
Mailing Address City, State, Zip Code (if payment should be mailed to a different address than Cardholder's address listed above):			
Patient's Last Name First Name Middle Initial	Date ofBirth: / /	Patient's Sex: ☐ Male ☐ Female	Relationship to Cardholder: ☐ Self ☐Dependent ☐Spouse ☐ Other
Employer Name:		Group Number:	
Employer Address, City, State, Zip Code:			
Do you or any member of your immediate family have other insurance which may cover all or part of this claim? Primary: ☐Yes ☐ No Secondary: ☐Yes ☐ No	If yes, please provide the insurance company name, ID number, and group number:		

B.– Claim Information: Important – Submit either Prescription receipts / labels or patient history print-out from your Pharmacy

Pharmacy ID#	Pharmacy Name:	Fill Date: / /	Rx Number:	QuantityDispensed:
DaysSupplied:	National Drug Code (11-digit NDC):	Prescriber:		Amount Paid:
Pharmacy ID#	Pharmacy Name:	Fill Date: / /	Rx Number:	Quantity Dispensed:
Days Supplied:	National Drug Code (11-digit NDC):	Prescriber:		Amount Paid:
Pharmacy ID#	Pharmacy Name:	Fill Date: / /	Rx Number:	Quantity Dispensed:
Days Supplied:	National Drug Code (11-digit NDC):	Prescriber:		Amount Paid:
Pharmacy ID#	Pharmacy Name:	Fill Date: / /	Rx Number:	Quantity Dispensed:
Days Supplied:	National Drug Code (11-digit NDC):	Prescriber:		Amount Paid:

C.– Reason for Claim Submission or Special Notes:

D.– Authorization:

I certify that the above information is true and correct to the best of my knowledge and hereby authorize any physician, pharmacy, employer, union, insurance company or HMO to supply any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original. I further assign to my Health Plan any rights I may have to be reimbursed for costs associated with the above claims and I authorize my health plan to pursue such reimbursement opportunities on my behalf. I certify that I shall not take any action that in any way limits my Health Plans ability to obtain reimbursements on my behalf for the claims noted above.

Patient's Signature:	Date Signed:

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND FILL OUT THE REVERSE SIDE OF THIS FORM

SECTION A – INSURED / PATIENT INFORMATION:

Complete this section for each family member who has received medication.

1.Print Cardholder's name (last, first, middle initial).
2.Print Cardholder's Identification (ID) Number (found on prescription drug or health insurance card).
3.Print Today's Date.
4.Print Cardholder's Address Information and Phone Numbers.
5.Print Mailing Address (if payment should be mailed to a different address than the Cardholder's address).
6.Print Patient's name (last, first, middle initial).
7.Print Patient's Date of Birth, Patient's Sex and Check Relationship to Cardholder (Self, Spouse,Dependent,Other).
8.Print Employer's Name, Group Number, and Address (refer to drug or health insurance card).
9.Indicate if covered under another insurance plan. Include the insurance company name, ID number, and group number.

SECTION B – CLAIM INFORMATION:

Submit either original prescription receipts/labels with this claim form and/or a patient history print-out from your pharmacy. Please do not staple, tape, or glue receipts to the form (it is preferable not to attach them).

Claims received missing any of the following information may be returned or payment may be denied:

- **Pharmacy ID#:** 7-digit Pharmacy Identifier (NCPDP Number)
- **Pharmacy Name:** Pharmacy Name
- **Fill Date:** Date that the prescription was dispensed
- **Rx Number:** Prescription Number
- **Quantity Dispensed:** Quantity of the drug dispensed
- **Days Supplied:** The number of days supply of the drug dispensed
- **National Drug Code (11-digit NDC):** 11-digit code for the drug dispensed
- **Prescriber:** Prescribing provider's name
- **Amount Paid:** The amount paid for the prescription

Note: Altered receipts require pharmacist's signature.

SECTION C – REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

This section can be used for special notes or comments.

SECTION D – AUTHORIZATION:

Patient's Signature and Date Signed. Please read authorization and assignment language closely.

IMPORTANT: Claim form must be signed. (Unsigned claim forms cannot be processed and will be returned)

Questions?

Call (866) 878-8479

Please return this claim to:

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Attn: Claims Reimbursement
7914 W. Dodge Road, No. 378
Omaha, NE 68114

IMPORTANT REMINDER: To avoid having to submit a paper claim form:

- Always have your ID card when getting a prescription.
- Use pharmacies within your network.
- Use medications included in the drug formulary for your plan.
- If you encounter problems at the pharmacy, call the number on the back of your ID card.