Prescription Drug Claim Form

Magellan Rx MANAGEMENT℠

Important: Please read instructions prior to completing.

1. Policyholder or Insured Name (First, Middle, Last) _____

   Address _____

   City _____ State _____ Zip Code _____

2. Policyholder or Insured ID No. *(as shown on ID Card)* _____

3. Why was your insurance or drug card not used for this purchase? _____

4. Employer Name _____

5. Patient's Name (First, Middle, Last) _____

6. Patient's Birth Date ____/____/____ (MM / DD / YY) 7. Patient's Sex ☐ M ☐ F

8. Patient's Relationship to Policyholder:

   ☐ Self (Male) ☐ Self (Female) ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other Male Dependent ☐ Other Female Dependent

9. Is the patient eligible for any other Prescription Drug Coverage? ☐ Yes ☐ No If Yes, you must complete the following:

   Does the other coverage include: ☐ Major Medical ☐ Drug ☐ Other Medical

   Insured's Name _____

   Spouse's Birth Date ____/____/____ (MM / DD / YY) Insured's ID Number _____ Effective Date _____

   Insurance Company Name _____

   Address (Street, City, State, Zip Code) _____

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Magellan Rx Management, it's agents or representatives.

Signature _____ **Date** _____

Please ask your pharmacist to fill out this section. We cannot process this claim without the following information. Fill out the information below or attach the original receipt to this form. No photocopies will be accepted.

Rx Number	Date Filled	Check One	Metric Quantity	Days Supply	MD Name / Prescriber ID No.	Is Rx	Rx Price (including tax)
1.		☐ New Rx ☐ Refill Rx				No DAW ☐ 0, MD DAW ☐ 1, Patient DAW ☐ 2, RPh DAW ☐ 3, No Generic ☐ 4	$
Reference Number: this is helpful	Medication Name, Strength Dosage Form			Is Drug Compound Rx ☐	NDC Number		
Rx Number	Date Filled	Check One	Metric Quantity	Days Supply	MD Name / Prescriber ID No.	Is Rx	Rx Price (including tax)
2.		☐ New Rx ☐ Refill Rx				No DAW ☐ 0, MD DAW ☐ 1, Patient DAW ☐ 2, RPh DAW ☐ 3, No Generic ☐ 4	$
Reference Number	Medication Name, Strength Dosage Form			Is Drug Compound Rx ☐	NDC Number		
Rx Number	Date Filled	Check One	Metric Quantity	Days Supply	MD Name / Prescriber ID No.	Is Rx	Rx Price (including tax)
3.		☐ New Rx ☐ Refill Rx				No DAW ☐ 0, MD DAW ☐ 1, Patient DAW ☐ 2, RPh DAW ☐ 3, No Generic ☐ 4	$
Reference Number	Medication Name, Strength Dosage Form			Is Drug Compound Rx ☐	NDC Number		

If more than three prescriptions, please fill out additional claim forms.

Pharmacy Name _____ Phone No. _____ Street _____ City _____ State _____ Zip _____

Provider ID No. _____ this is helpful but not required

Pharmacist Signature

Note: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of Magellan Rx Management.

Please return completed form to the address shown on reverse side.

Instructions

Policyholder:

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims that were purchased without using your drug card, or due to an emergency situation.
2. You will be reimbursed directly for all covered services up to the allowed amount.
3. Complete all items in the top section for both the patient and policyholder.
4. Use a separate form for each patient.
5. Sign the form in the area provided.
6. Be sure to include the detailed pharmacy receipt for each claim with this form (copies are acceptable).
7. Please include the medication name, NDC number, strength, dosage form, quantity , and billed amount for each compound ingredient.
8. For a list of participating pharmacies in your area, please refer to our website www.magellanrx.com or call your customer service area.
9. Mail completed form to Magellan Rx Management, 11013 West Broad Street, Suite 500, Glen Allen, VA 23060.
10. **If you have any questions, please call your Customer Service Area.**

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Insurance Fraud Warning

It is unlawful to knowingly provide, false incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.