Prescription Drug Claim Form

Instructions: *Please read carefully the following instructions before completing this form*
Claim forms with missing information cannot be processed and will be returned to the sender

Part 1: member information (to be completed by the member)

1. Complete all information in Part 1. The member or subscriber ID number is located on your health plan ID card.
2. A claim must be submitted to Moda Health within 90 days of the date the expense was incurred. Under no circumstances will claims submitted later than one year from that date be considered valid, except in the case of legal incapacity.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.Payment and related correspondence will be sent to the primary subscriber unless you have made arrangements with Moda Health to send to an alternate address.

Part 2: receipt information

1. Submit detailed prescription receipts or labels that contain the requested information (shown below), or have your pharmacy representative complete Part 2 and Part 3. If you do not submit a detailed prescription receipt for your prescription(s), a pharmacy representative signature is required.
2. Include a copy of your pharmacy receipt(s). Photocopy receipts and submit with the claim form. Note: please do not staple receipts or other documentation to the claim form.
3. If you have more than one claim, submit a separate Part 2 for each medication or use the multiple prescription alternative form.
4. Receipts for the administration of vaccines require completion of Part 2 and Part 3. A pharmacy representative signature is required.
5. Compounded medications require a separate Compound Claim Form.
6. Receipts for medication purchased outside the U.S. must be translated into English, including conversion of currency conversion into U.S. dollars. You also must include the required prescription and pharmacy information as indicated below.

PRESCRIPTION AND PHARMACY INFORMATION

Prescription 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 ***NDC #00000-1111-22** ***QTY: 45** ***Days Supply: 30** ***U&C: 200.00** ***COPAY: 20.00**	1. Patient name* 2. Patient date of birth* 3. Date filled* 4. Quantity* 5. Day supply* 6. National drug code (NDC)* 7. Medication name and strength* 8. Usual and customary price (U&C)/RX price* 9. Copay* 10. Pharmacy NPI or NABP number* ***REQUIRED INFORMATION—CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED***

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Part 3: pharmacy information (to be completed by the pharmacy)

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

Send the completed form and receipt(s) to: Moda Health
P.O. Box 40168
Portland, OR 97240-0168
Fax: 800-207-8235, ATTN: Rx Claims Department

Prescription Drug Claim Form

PART 1: *indicates required information

Primary member/subscriber ID number*	Group number	
Group/employer name	Primary subscriber name*	Subscriber date of birth: (mm/dd/yyyy)* / /
Patient name: (first, middle, last)*	Date of birth: (mm/dd/yyyy)* / /	Relationship to primary subscriber Self ☐ Spouse ☐ Dependent ☐ Domestic partner ☐
Address: (Street, City, State, ZIP code)		
Does this member have prescription coverage under any other group health plan? ☐ Yes ☐ No If yes, provide the name of the health plan and other employer _____		
I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.		
Member signature*	Telephone number ( )	Date

Indicate reasons for filing a claim(s) (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 health plan payment)
☐ Medicare is primary prescription coverage
☐ Discount card was used
☐ Health plan, health coverage information or health plan ID card was not available at the time of purchase
☐ Pharmacy not participating in network
☐ Pharmacy unable to process claim electronically
☐ Emergency—please explain _____
☐ Worker's compensation
☐ Prescription purchased outside the U.S. Please see claim instructions on previous page.
☐ Other _____

Submission of claims does not guarantee reimbursement.

PART 2

moda HEALTH

Prescription Drug Claim Form

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*		Physician name and NPI number Name: ________________________ NPI: _________________________		RX price* Admin fee $	Vaccine admin fee $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*		Physician name and NPI number Name: ________________________ NPI: _________________________		RX price* $	Vaccine admin fee $	Copay* $

Is this a compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients and 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 or NABP*	
City	State	Zip	Pharmacy representative signature*	Date*

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*		Physician name and NPI number Name: ________________________ NPI: _________________________		RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*		Physician name and NPI number Name: ________________________ NPI: _________________________		RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*		Physician name and NPI number Name: ________________________ NPI: _________________________		RX price* $	Vaccine admin fee $	Copay* $

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RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)* ☐☐☐☐☐☐☐☐☐☐☐
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)* ☐☐☐☐☐☐☐☐☐☐☐
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)* ☐☐☐☐☐☐☐☐☐☐☐
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)* ☐☐☐☐☐☐☐☐☐☐☐
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________	RX price* $	Vaccine admin fee $	Copay* $