Amerihealth Insurance Company of New Jersey
QCC Insurance Company d/b/a Amerihealth Insurance Company
Amerihealth HMO, Inc.

13477
REV 03/05

Prescription Reimbursement Claim Form

Part 1
Cardholder/ Patient Information

Part 1 must be fully completed to ensure proper reimbursement of your drug claim.

Please type or print clearly.

Cardholder ID No. ____ Group No./Group Name ____

Cardholder Name ____ Address ____

City ____ State ____ ZIP ____ Phone ( )

Patient Information — Use a separate claim form for each family member

Patient Name ____ Date of Birth ____

Patient: ❍ Male ❍ Female Relationship: ❍ Member ❍ Spouse ❍ Child ❍ Other ____

Are any of these medications being taken for an on-the-job injury? ❍ Yes ❍ No

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for prescription benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to Caremark, the prescription benefit manager; insurance underwriter; plan sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

x ____

Signature of Cardholder or Legal Representative **Date**

Part 2
Important!
Please remember to include all original pharmacy receipts.

If you are including all original receipts with the following information, STOP HERE and submit the claim. It is not necessary to complete Part 3. **NOTE:** Do not staple or tape receipts or attachments to this form.

- Member Name
- Date of Purchase
- Metric Quantity/Days Supply
- Prescription Number
- Total Charge
- Drug Name
- Drug Strength or NDC Number
- Pharmacy Name and Address or NABP Number

Part 3
Pharmacy Information

Pharmacist to complete this section ONLY if original pharmacy receipts are not included.

- To ensure that your patient receives accurate and timely reimbursement for medication purchases, please assist in completing the information below.
- If compound prescription, please enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescriptions section on the reverse side.

Pharmacy Name ____ Pharmacy NABP No. ____

Pharmacy Address ____ City ____

State ____ ZIP ____ Phone ( )

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the cardholder.

x ____

Signature of Pharmacist or Representative **Date**
(Required only if original pharmacy receipts are not included)

Rx 1

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code

NDC #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

Rx 2

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code

NDC #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

Rx 3

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code

NDC #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each patient
- Each pharmacy from which you purchase prescription drugs

CLAIM SUBMISSION

When submitting a claim, the following information must be included:

- Member Name
- Prescription Number
- Date of Purchase
- Drug Name
- Total Charge
- Pharmacy Name and Address or NABP Number
- Drug Strength/NDC Number
- Metric Quantity/Days Supply
- Original Pharmacy Receipts
- Pharmacist's Signature (only if original pharmacy receipts are not included)

DO NOT submit canceled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

HOW TO COMPLETE THIS FORM

Cardholder / Patient Information

Complete all cardholder and patient information in Part 1 on reverse side.

- The cardholder ID number can be found on your ID card.
- The group is the name of your company or association through which you have coverage.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Caremark. No documents will be returned.

PHARMACY INFORMATION

Pharmacist to complete Part 3 of the form

- Indicate pharmacy name, NABP number, address and phone number.
- Include Rx number(s), drug name(s), strength(s) and date filled.
- Indicate prescriber's DEA number and whether the prescription is new, refill, DAW or compound.
- Include NDC number(s) for the drug(s) dispensed.
- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables.
- Indicate the "days supply" (the number of days the medication will last).
- Indicate the dollar amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call Caremark at 1-800-364-6331.

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC #	Drug Ingredient	Quantity	Charge

MAIL THIS FORM TO:

Caremark Claims Department / P.O. Box 52136 / Phoenix, AZ 85072-2136
If you have questions, please contact: Caremark toll-free at 1-877-252-3485.
Monday–Friday, 7 a.m.–10 p.m. CST / Saturday, 8 a.m.–8 p.m. CST / Sunday, 8 a.m.–4:30 p.m. CST
Closed on national holidays.