



## Secondary Insurance Prescription Drug Claim Form

**INSTRUCTIONS:**

- This form is to be used for **secondary** prescription claim submissions only. Call the Customer Service number listed on the back of your ID card for the proper form for primary insurance claim submission.
- Complete all information, following all instructions carefully. An incomplete form and/or missing attachments may delay your reimbursement.

1. SUBSCRIBER / PATIENT / PHARMACY INFORMATION — <i>complete a separate form for each person and each pharmacy</i>			
Subscriber (employee) name		Patient name	
Subscriber ID number	Subscriber group number	Patient relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse / domestic partner <input type="checkbox"/> Dependent	
Subscriber employer's name		Pharmacy name	
Subscriber mailing address		Pharmacy mailing address	

2. PRESCRIPTION DRUG RECEIPTS — <i>limit 10 receipts per form</i>								
<ul style="list-style-type: none"> <li>• List prescription drugs in date order, limiting 10 receipts per form. Use a separate form for additional receipts.</li> <li>• All prescriptions listed must be for the same person and same pharmacy. Use a separate form for each person, each pharmacy.</li> <li>• Receipts must be attached. Do not staple! Tape receipts to reverse side or on a separate sheet. Cash register receipts are not acceptable.</li> <li>• Explanation of benefits (EOB) from primary insurance or pharmacy receipt indicating copay amount from primary coverage must also be attached.</li> </ul>								
	Date of Purchase	Amount Charged	Balance after Primary Ins. Benefits	Drug Quantity Units/Days	Name of Each Drug	Rx Number	Prescribing Physician	Receipt and EOB attached?
						NDC Number		
1								<input type="checkbox"/> Yes <input type="checkbox"/> No
2								<input type="checkbox"/> Yes <input type="checkbox"/> No
3								<input type="checkbox"/> Yes <input type="checkbox"/> No
4								<input type="checkbox"/> Yes <input type="checkbox"/> No
5								<input type="checkbox"/> Yes <input type="checkbox"/> No
6								<input type="checkbox"/> Yes <input type="checkbox"/> No
7								<input type="checkbox"/> Yes <input type="checkbox"/> No
8								<input type="checkbox"/> Yes <input type="checkbox"/> No
9								<input type="checkbox"/> Yes <input type="checkbox"/> No
10								<input type="checkbox"/> Yes <input type="checkbox"/> No

3. SUBSCRIBER SIGNATURE	
I hereby certify that the above drugs were necessary for treatment of the illness/injury reported and were purchased for the individual named above.	
<b>X</b>	Date