



COORDINATION OF BENEFITS AND MEMBER PRESCRIPTION CLAIM REIMBURSEMENT FORM

MEDICARE/MEDICAID PRESCRIPTION DRUG COVERAGE

Use this claim form to seek reimbursement for prescriptions obtained without the use of your pharmacy benefit plan or for prescriptions received through your primary prescription insurance benefit. Reimbursement will be based upon your plan's current copayments from a network pharmacy. You will be responsible for any difference in price between the copayment and the actual amount paid. For questions, call the phone number listed on your ID card. **Only one enrollee per form.**

Group Name: First Medical Health Plan, Inc. RxGrp # (from ID card): 638017

ENROLLEE INFORMATION

Name: _____ ID# (from ID card): _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Birth Date (MM/DD/YYYY): _____ Reason for Reimbursement: _____

TYPE OF CLAIM

- I am seeking reimbursement for a prescription obtained...
 - without the use of my Pharmacy Benefit Plan. **(skip to bottom)**
 - using another primary prescription insurance benefit. **(cont. to #2)**
- Under my other Primary Prescription Insurance, I have a(n)...
 - ID card*
 - benefit through a medical insurance plan**

* - A **copy** of your primary prescription insurance ID card.
 - The **original** primary insurance prescription receipt showing the copayment amount you paid.

** - A **copy** of the Explanation of Benefits showing your prescription out-of-pocket amount paid.
 - The **original** prescription receipt showing the amount you paid at the pharmacy.

PHARMACY/PRESCRIPTION INFORMATION

Drug Name	Total Quantity	Days Supply	Amount Paid \$
Pharmacy NCPDP #: <i>(if unknown, contact the pharmacy)</i>	NDC #: <i>(if unknown, contact the pharmacy)</i>		
NPI #: <i>(if unknown, contact the pharmacy)</i>			
Drug Name	Total Quantity	Days Supply	Amount Paid \$
Pharmacy NCPDP #: <i>(if unknown, contact the pharmacy)</i>	NDC #: <i>(if unknown, contact the pharmacy)</i>		
NPI #: <i>(if unknown, contact the pharmacy)</i>			

I certify the prescription(s) referred to above have been received and information stated is accurate. I also authorize the release of all information contained herein to Walgreens Health Initiatives and its agents. I understand that all prescription receipts must be submitted in order to be processed and considered for reimbursement.

Enrollee Signature*: _____ Date: _____

*If the individual cannot sign, a person who is authorized to do so under state law in the state where the individual resides must sign above. This signature certifies that the person signing is authorized under state law to complete this form and that documentation of this authority is available upon request by the plan or by the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare.

MAIL THIS CLAIM FORM, ALONG WITH BOTH THE PRESCRIPTION AND CASH REGISTER RECEIPT TO:

First Medical Health Plan, Inc. · Dept. de Farmacia First Plus · PO Box 195080 · San Juan, PR 00919

CLAIM INFORMATION

Only complete the section that applies to you. For questions concerning your prescription, please contact the pharmacy in which the medication was dispensed. For questions concerning this form, please call 1-800-207-2568.

(EXAMPLE A) PRESCRIPTION RECEIPT

Pharmacy
123 Townline Rd
Chicago, IL 12345
3274
PH: (630)555-1234
Fill Date 01/04/05
Prescriber Dr. Thomas
RX#: 1234567
JOHN DOE
TAKE ONE CAPSULE BY MOUTH
THREE TIMES A DAY FOR TEN DAYS.
AMOXICILLIN 500MG CAPSULES by PFIZER
QTY 30 Refills 0 By 01/04/05
Orig. Date 01/04/05 \$100.00

1
2
3

Use these examples only as a guide to locate the required information. Each pharmacy may have their own unique label format.

Please Note:

Based on your usual copayments, and the insurance companies policies and procedures, you will receive 0-100% reimbursement.

- 1 The name of the medication prescribed
- 2 The amount of pills or liquid medication dispensed
- 3 The amount the *patient* paid for the medication

PHARMACY/PRESCRIPTION INFORMATION – Pharmacy/Prescription Information (Example A)

Drug Name	Total Quantity	Days Supply	Amount Paid \$
Pharmacy NCPDP #: (if unknown, contact the pharmacy)	NDC #: (if unknown, contact the pharmacy)		
NPI #: (if unknown, contact the pharmacy)			
Drug Name	Total Quantity	Days Supply	Amount Paid \$
Pharmacy NCPDP #: (if unknown, contact the pharmacy)	NDC #: (if unknown, contact the pharmacy)		
NPI #: (if unknown, contact the pharmacy)			
Drug Name	Total Quantity	Days Supply	Amount Paid \$
Pharmacy NCPDP #: (if unknown, contact the pharmacy)	NDC #: (if unknown, contact the pharmacy)		
NPI #: (if unknown, contact the pharmacy)			
Drug Name	Total Quantity	Days Supply	Amount Paid \$
Pharmacy NCPDP #: (if unknown, contact the pharmacy)	NDC #: (if unknown, contact the pharmacy)		
NPI #: (if unknown, contact the pharmacy)			

PLEASE MAKE SURE ALL NECESSARY INFORMATION IS COMPLETED. ANY INCOMPLETE INFORMATION MAY CAUSE A DELAY IN PROCESSING OR A RETURN OF THIS FORM.