



PRESCRIPTION DRUG CLAIM FORM

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|---|-------------------|---------------|---|
| Cardholder's Name (last, first, MI) | Date of Birth | Gender M F | Cardholder ID Number |
| If this is a new address please check _____ | | | |
| Address | Street | City/State | ZipCode _____ Daytime Telephone () _____ |
| Employer | Insurance Carrier | Group Number | |

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained in this claim to Sentara Health Management and my Plan Sponsor.

Cardholder's Signature _____ Date _____

Patient Information (please list information for each patient submitting claims)

| | | | | | |
|----------|----------------------------|---|------------------------|---|----------------------------------|
| 1 | Patient's Name | Relationship to Cardholder? (circle) self, spouse, dependant | Gender (circle) M F | Date of Birth | How many prescriptions attached? |
| | Pharmacy Name and Address: | | | Physician Name (name of prescribing Doctor) and DEA#: | |

| | | | | | |
|----------|----------------------------|---|------------------------|---|----------------------------------|
| 2 | Patient's Name | Relationship to Cardholder? (circle) self, spouse, dependant | Gender (circle) M F | Date of Birth | How many prescriptions attached? |
| | Pharmacy Name and Address: | | | Physician Name (name of prescribing Doctor) and DEA#: | |

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|----------|----------------------------|---|------------------------|---|----------------------------------|
| 3 | Patient's Name | Relationship to Cardholder? (circle) self, spouse, dependant | Gender (circle) M F | Date of Birth | How many prescriptions attached? |
| | Pharmacy Name and Address: | | | Physician Name (name of prescribing Doctor) and DEA#: | |

Is claim for Diabetic Supply? yes no if Yes, Patient's name _____
 Type of supply (lancets, syringe, etc.) _____ Quantity _____ Days Supply _____
 Does the patient reside in an assisted living facility? yes no Is this claim for allergy serum? yes no
 Does the patient have primary prescription drug coverage through another insurance carrier? Yes _____ no _____
 Did the patient submit this claim to the carrier? yes no If yes, please attach an explanation of benefits from your primary carrier.

Prescription Information

→ **IMPORTANT** ← All prescription claims must have prescriptions receipts/labels which include:
 Pharmacy Name/Address *Date Filled *Drug Name, Strength and NDC *RX Number *Quantity *Days Supply *Price *Patient's Name
Claims received missing any of the above information may be returned or payment may be denied or delayed
 Please tape receipts to separate piece of paper
 Patient history print outs from the pharmacy are also acceptable but **MUST** be signed by the Pharmacist.
 CASH REGISTER RECEIPTS ARE **NOT** ACCEPTABLE FOR ANY PRESCRIPTIONS.
 (With the exception of diabetic supplies)

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

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If a member is eligible for pharmacy reimbursement, he or she should follow the steps below to receive reimbursement for a prescription.

- Complete the Direct Member Reimbursement Form. Be sure to include the member ID number on this request. This number is located on the Member ID card.
- Be sure to send the prescription (the piece of paper that was stapled to the bag).
- Mail the request and prescription receipt to:
Pharmacy Authorization Coordinators
Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462
- Plan members will be reimbursed allowable charges less the applicable copay. This applies to Point-of-Service (POS) and PPO members. HMO members may be reimbursed, but only in emergency situations.

All requests for pharmacy reimbursement are subject to plan guidelines, policies and procedures. For example, if a drug requires pre-authorization and has rejected at the pharmacy, it is not eligible for reimbursement.