



PRESCRIPTION DRUG CLAIM FORM

INSURED INSTRUCTIONS — A separate claim form must be completed for each patient.

ATTACH RECEIPTS HERE

1. Complete all information requested under Part A.
2. If you used an Empire Pharmacy Management Participating Pharmacy, complete Part B using the information provided to you by your pharmacist and include your detailed pharmacy receipt (not a cash register receipt)
3. If you did NOT use an Empire Pharmacy Management Participating Pharmacy, please provide your detailed pharmacy receipt (not a cash register receipt).
4. Review, sign and mail completed form with receipt(s) to:
 Empire Pharmacy Management
 P.O. Box 5099
 Middletown, NY 10941-9099

NOTE: Please allow up to 30 days for payment. If you have any questions regarding this form, please call Empire Pharmacy Management at 1-800-839-8442.

IMPORTANT: MISSING INFORMATION MAY CAUSE A DELAY IN PAYMENT.

Part A — INSURED/PATIENT INFORMATION

INSURED'S NAME: LAST		FIRST		M.I.	DAYTIME PHONE NUMBER ()
INSURED'S STREET ADDRESS					
CITY		STATE	ZIP CODE	GROUP NO.	INSURED'S ID NO. (ON ID CARD)
PATIENT'S NAME: LAST		FIRST		M.I.	PATIENT CODE: (2-digit code next to patient's name on ID card)
PATIENT'S DATE OF BIRTH:		MONTH	DAY	YEAR	PATIENT'S RELATIONSHIP TO INSURED
				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD

Do you or your dependents have other insurance covering this claim and is the other insurance PRIMARY? YES NO
 IF "YES," please attach an Explanation of Benefits from your other insurance and a copy of the receipts.

PART B — PARTICIPATING PHARMACY — PRESCRIPTION INFORMATION

List the claim authorization no. (also known as audit no.) for each prescription below and **ATTACH ALL RECEIPTS** for each prescription to this form.

- | | | | |
|----------|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ | 7. _____ |
| 2. _____ | 4. _____ | 6. _____ | 8. _____ |

*The claim authorization number may be found on your receipt, or ask your pharmacist for the number.

PART C — NON-PARTICIPATING PHARMACY — PRESCRIPTION INFORMATION

All information below must be completed for reimbursement.

NABP NO. (7 digits)	DATE DISPENSED	Rx NO.	NATIONAL DRUG CODE (11 digits)	DAYS SUPPLY	TOTAL PAID*
1.					
2.					
3.					
4.					

*Actual amount paid by insured/patient to pharmacist.

AUTHORIZATION: I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, pharmacist, HMO or prepayment organization to supply the Plan Administrator and its agents any information required in connection with this claim. A photocopy of this authorization shall be valid as the original.

INSURED'S SIGNATURE: _____ DATE SIGNED: _____

PRESCRIPTION DRUG CLAIM FORM FILING INSTRUCTIONS

In order to ensure that your claim is processed promptly and accurately, please follow these instructions when submitting a claim for prescription drug services. You must use the prescription drug claim form in order to receive reimbursement for your claims. Complete a separate form for each patient.

1. **For all prescription drug claims, complete Part A as follows:**
 - **Name - Address - Phone Number of insured.**
 - **Group No.** - This is the insured's designated group number. It is found on the insured's Prescription ID Card.
 - **Insured's ID No.** - The insured's Member Number is also found on the Prescription ID Card.
 - **Patient's Name, Date of Birth and Relationship** to the insured.
 - **Patient Code** - This is the two-digit number next to the patient's name on the Prescription ID Card. It is used to identify which family member received the prescription.
 - **Primary Insurance** - This indicates if the patient has other insurance that would be considered primary which would also cover this claim. When one or more family members are covered under more than one group plan, "primary" indicates which carrier the claim should be submitted to first. Therefore, if the other insurance is primary, you must first submit your claim to that insurance carrier. In order to receive secondary coverage under Empire Pharmacy Management for the remainder, attach the **Explanation of Benefits (EOB)** from the other (primary) insurance carrier and a copy of the receipt.

2. **If you used a participating pharmacy, complete both Part A and Part B, as follows:
(leave Part C blank)**
 - **Claim Authorization No.** - In some cases, this eight-digit number will appear on your receipt from the pharmacy. If not, be sure to ask your pharmacist for this number when you pick up your prescription. You must include this number when submitting a claim.
 - **Attach an original receipt** for each prescription to the upper left corner of the claim form.
 - **The insured should sign and date the authorization.**

3. **If you used a nonparticipating pharmacy, complete both Part A and Part C, as follows:
(leave Part B blank)**
 - **NABP No.** - The NABP number is the seven-digit National Association Board of Pharmacy number. If it is not on your receipt, ask your pharmacist for the number.
 - **Date Dispensed** - The date your prescription was dispensed.
 - **Rx No.** - This is the pharmacy's number for your prescription and is usually found on your receipt.
 - **National Drug Code** - This is an 11-digit number used as a drug identifier. You must record this number on your claim. If it is not on your receipt, ask the pharmacist for this number.
 - **Days Supply** - This represents the expected number of days the prescription will last (i.e., a prescription of 90 units taken three times per day represents a 30-day supply).
 - **Total Paid** - This is the amount you actually paid.
 - **Attach an original receipt** for each prescription to the upper left corner of the claim form.
 - **The insured should sign and date the authorization.**

4. **Send your completed claim form with attached receipts to:**

Empire Pharmacy Management
P.O. Box 5099
Middletown, NY 10941-9099

If you have any questions completing this form, please call Empire Pharmacy Management at 1-800-839-8442.