

# Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information.  
An incomplete form may delay your reimbursement.



## Member/Subscriber Information *See your prescription drug ID card.*

Group no. **H N R X S**

Member ID

Member name (first, last)

Street address

City   State   Zip

## Patient Information

Patient name (first, last)

Patient date of birth (month/day/year)

Sex *Relation to plan member*

- |                                 |  |   |
|---------------------------------|--|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self              | <input type="checkbox"/> 5 Disabled dependent |
| <input type="checkbox"/> Male   | <input type="checkbox"/> 2 Spouse            | <input type="checkbox"/> 6 Dependent parent   |
|                                 | <input type="checkbox"/> 3 Eligible child    | <input type="checkbox"/> 7 Other              |
|                                 | <input type="checkbox"/> 4 Dependent student | <input type="checkbox"/> 8 Nonspouse partner  |

## Pharmacy Information

Name of pharmacy

Street address

City   State   Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy?  Yes  No

## Claim Receipts

Tape claim receipts or itemized bills on the back.

**Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

- Is a compound prescription.**  
If so, make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and ingredients and quantities on the receipt.
- Was purchased outside the United States.**  
If so, please indicate:  
Country \_\_\_\_\_  
Currency used \_\_\_\_\_
- Is for treatment of an allergy.**

## Coordination of Benefits

(Another health plan has paid a portion.)  
Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

- Yes  No
- 1 Another health plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid.
- 3 Card program
- 4 **Medco By Mail**/mail-order pharmacy

## Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury. I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.

**X** \_\_\_\_\_  
Signature of member

