

# Prescription Drug Claim Form



**Important: Please read instructions prior to completing this form.**

**Policyholder:**

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims purchased without using your drug card.
2. For a list of participating pharmacies in your area, please refer to our website at [www.cap-rx.com](http://www.cap-rx.com) or call the Customer Service number on the back of your Prescription Drug Card.
3. Please provide all information requested in **Section 1** for both the patient and policyholder.
4. Sign and date the form in the area provided.
5. Have your pharmacist complete **Section 2 on page 2** of the form.
6. Mail completed form along with the original pharmacy and cash register receipts to: **Capital Rx, Inc. Attn: Claims Dept., 228 Park Avenue, South, Suite 87234, New York, NY 10003.**
7. If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
8. Incomplete forms may be returned and/or delay the process.
9. Please make copies of all documents for your own records.
10. Once your claim is successfully processed, you will be reimbursed directly for all covered services up to the allowed amount.
11. Reimbursement is not guaranteed and are subject to your plan's limits, exclusions and provisions.  
**See Note on bottom of page 2.**

## **SECTION 1**

1. Policyholder or Insured Name (First, Middle, Last) \_\_\_\_\_  
Address \_\_\_\_\_
2. City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
3. Policyholder or Insured ID No. (as shown on ID Card) \_\_\_\_\_
4. Why was the insurance or drug card not used for this purchase? \_\_\_\_\_
5. Plan or Employer Name \_\_\_\_\_
6. Patient's Name (First, Middle, Last) \_\_\_\_\_
7. Patient's Birth Date \_\_\_\_\_
8. Patient's Relationship to Policyholder:  Self  Spouse  Child  Other Dependent
9. Is the patient eligible for any other Prescription Drug Coverage?  Yes  No

**If yes, complete the following:**

Does the other coverage include:  Major Medical  Drug  Other Medical

Insured's Name \_\_\_\_\_ Insured's ID Number \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Address (Street, City, State, Zip Code) \_\_\_\_\_

**I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Capital Rx.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Pharmacist:**

1. Please provide all information requested in **Section 2**.
2. Attach the original receipt and prescription information received on your prescription bag to this form.
3. Sign and date the form in the area provided.

**Important:** Please complete additional claim forms if the member has more than two prescriptions!

## SECTION 2

**Fill out the information below and attach the original receipt and prescription information received on your prescription bag to this form.**

1.Rx Number	Date Filled	Check One <input type="checkbox"/> New Rx <input type="checkbox"/> Refill Rx	Metric Quantity	Days Supply	MD Name	Is Rx No DAW MD DAW Patient DAW RPh DAW No Generic	Rx Price (including tax)	
							<input type="checkbox"/> 0	<input type="checkbox"/> 1
					Prescriber ID No.		Ingredient Cost \$	
							Gross Cost \$	
Medication Name, Strength, Dosage Form			Is Drug Compound Rx <input type="checkbox"/>		NDC Number (if compound, include NDCs for all active ingredients)			U&C Cost \$
Compound Ingredient 2			Metric Quantity		NDC Number			
Compound Ingredient 3			Metric Quantity		NDC Number			
Compound Ingredient 4			Metric Quantity		NDC Number			
2. Rx Number	Date Filled	Check One <input type="checkbox"/> New Rx <input type="checkbox"/> Refill Rx	Metric Quantity	Days Supply	MD Name	Is Rx No DAW MD DAW Patient DAW RPh DAW No Generic	Rx Price (including tax)	
							<input type="checkbox"/> 0	<input type="checkbox"/> 1
					Prescriber ID No.		Ingredient Cost \$	
							Gross Cost \$	
Medication Name, Strength, Dosage Form			Drug Compound Rx <input type="checkbox"/>		NDC Number (if compound, include NDCs for all active ingredients)			U&C Cost \$
Compound Ingredient 2			Metric Quantity		NDC Number			
Compound Ingredient 3			Metric Quantity		NDC Number			
Compound Ingredient 4			Metric Quantity		NDC Number			

Please complete additional claim forms if the Member has more than two prescriptions.

Pharmacy Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Provider NPI \_\_\_\_\_ Pharmacist Signature \_\_\_\_\_

**Important:** Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to Capital Rx's approval.

Please return completed form along with the original pharmacy and cash register receipts to  
**Capital Rx, Inc. Attn: Claims Dept., 228 Park Avenue South, Suite 87234, New York, NY 10003.**

**Note:** Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

**Insurance Fraud Warning:** It is unlawful to knowingly provide, false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.