Prescription Drug Claim Form

Anthem Prescription

Important: Please read instructions on reverse side.

1. Policyholder Name _____
FIRST MIDDLE LAST

Address _____

City _____ State _____ Zip Code _____

2. Policyholder ID No. (as *shown on ID Card*) _____

3. Why was your insurance card not used for this purchase? _____

4. Employer Name _____

5. Patient's Name _____
FIRST MIDDLE LAST

6. Patient's Birthdate ____/____/____ 7. Patient's Sex ☐ M ☐ F
MM DD YY

8. Patient's Relationship to Policyholder:

☐ Self (Male) ☐ Self (Female) ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other Male Dependent ☐ Other Female Dependent

9. Is the patient eligible for any other Prescription Drug Coverage? ☐ Yes ☐ No

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 Anthem Prescription Management, LLC, its agents or representatives.

Signature _____ **Date** _____

Please ask your Pharmacist to fill out this section.

We cannot process this claim without the following information.
Fill out the information below or attach the original receipt to this form.

Rx number	Date filled	Check one	Metric quantity	Days supply	MD name / DEA Number	Is Rx	Rx price (including tax)
1.		New Rx ☐ Refill Rx ☐				No DAW ☐0 MD DAW ☐1 Patient DAW ☐2 RPh DAW ☐3 No Generic ☐4	$
Reference number	Medication name, strength dosage form			Is drug compound Rx ☐	NDC number		
2.		New Rx ☐ Refill Rx ☐				No DAW ☐0 MD DAW ☐1 Patient DAW ☐2 RPh DAW ☐3 No Generic ☐4	$
Reference number	Medication name, strength dosage form			Is drug compound Rx ☐	NDC number		
3.		New Rx ☐ Refill Rx ☐				No DAW ☐0 MD DAW ☐1 Patient DAW ☐2 RPh DAW ☐3 No Generic ☐4	$
Reference number	Medication name, strength dosage form			Is drug compound Rx ☐	NDC number		

If more than three prescriptions, please fill out additional claim forms.

Pharmacy name Phone No. Street City State Zip

Pharmacist Must Fill Out

PHARMACY NABP ID No.

_____
Signature of pharmacist

NOTE: 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 the approval of Anthem Prescription Management, LLC.

Please return completed form to the address shown on the reverse side.

Instructions

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 that were purchased without using your drug card, or due to an emergency situation.
2. You will be reimbursed directly for all covered services up to the allowed amount.
3. Complete all items in the top section for both the patient and policyholder.
4. Sign the form in the area provided.
5. Be sure to include the original cash receipt with this form, and make copies for your own records.
6. Have your pharmacist complete the bottom section of the form.
7. Fold this form as marked, affix stamp, and mail it to the address below.
8. For a list of participating pharmacies in your area, visit our web site at www.anthemprescription.com, refer to your member enrollment Network Chain Pharmacy List, or call your customer service area.

Pharmacist:

1. Complete all items in the lower portion of this form.
2. Use a separate form for each patient.
3. Be sure to sign the form in the area provided.

If you have any questions, please call your Customer Service area.

Fold here

Insurance Fraud Warning

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insured, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fold here

Place Stamp Here. The Post Office Will Not Deliver Mail Without Postage

ANTHEM PRESCRIPTION MANAGEMENT LLC
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CINCINNATI OH 45250-5433