ConnectiCare

PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS – PLEASE PRINT ALL SECTIONS

1. This form is to be used to seek reimbursement from ConnectiCare for prescription drug costs you paid above the cost-share amounts outlined under your plan's prescription drug benefits.
2. Complete all sections of this form. We need all the information requested to process your claims.
3. Have your pharmacist complete sections C, D1, D2, and D3. All prescription receipts must be attached.
4. Refer to your ConnectiCare Medicare member ID card for the member information requested.
5. Use a separate form for each subscriber/patient.
6. Send this form and receipts to:

Express Scripts:
Attn: Medicare Part D
Address: P.O. Box 14718
Lexington, KY 40512-4718
Fax Number: 608-741-5483

If you have questions, call ConnectiCare at **800-224-2273** (TTY: **711**), 8 am to 8 pm, Monday to Friday. A representative is happy to help.

A. SUBSCRIBER INFORMATION ID #	**FOR OFFICE USE** Claim #
Subscriber Name (Last) (First) (MI)	
Street Address	
City	State ZIP
SUBSCRIBER SIGNATURE:	

B. PATIENT INFORMATION

Patient's Name (Last) (First) (MI)		
Date of Birth___/___/____	Male Female Patient's ID #	Patient's relationship to insured: Self Spouse Dependent
I certify that all subscriber and patient information is correct and the medication has been dispensed. I authorize release of any information relating to this claim to ConnectiCare and all necessary third parties for purposes of claims investigation and payment, utilization review, and audit.		
PATIENT'S SIGNATURE:		

C. PHARMACY INFORMATION NABP #	Telephone # - -	Pharmacy Name
Pharmacy Street Address		
City		State ZIP
Pharmacist's Signature		

D1. PRESCRIPTION INFORMATION Date Dispensed		Name of Medication			Rx #
NDC #	New Refill	Qty Dispensed	Strength	Days Supply	Prescription Cost $__,_____.
Prescriber's Name				Prescriber's State License #	

D2. PRESCRIPTION INFORMATION Date Dispensed		Name of Medication			Rx #
NDC #	New Refill	Qty Dispensed	Strength	Days Supply	Prescription Cost $__,_____.
Prescriber's Name				Prescriber's State License #	

D3. PRESCRIPTION INFORMATION Date Dispensed		Name of Medication			Rx #
NDC #	New Refill	Qty Dispensed	Strength	Days Supply	Prescription Cost $__,_____.
Prescriber's Name				Prescriber's State License #	

The formulary and pharmacy network may change at any time. You will receive notice when necessary.