Prescription Drug Claim Form

Important: Please read instructions prior to completing.

1. Policyholder or Insured Name (First, Middle, Last) ______
   Address ______
   City ______ State ______ Zip Code ______
2. Policyholder or insured ID No. (as shown on ID Card) ______
3. Why was the insurance or drug card not used for this purchase? ______
4. Employer Name ______
5. Patient's Name (First, Middle, Last) ______
6. Patient's Birth Date ______
7. Patient's Sex ☐ Male ☐ Female
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 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** ______

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. No photocopies will be accepted.

1.Rx Number	Date Filled / Prescription Date	Check One ☐ New Rx ☐ Refill Rx / Number of Refills	Metric Quantity	Days Supply	MD Name / Prescriber ID No.	Is Rx: No DAW ☐ 0, MD DAW ☐ 1, Patient DAW ☐ 2, RPh DAW ☐ 3, No Generic ☐ 4	Rx Price (including tax) $
Medication Name, Strength, Dosage Form			Is Drug Compound Rx ☐		NDC Number (if compound, include NDCs for all active ingredients)		
2. Rx Number	Date Filled / Prescription Date	Check One ☐ New Rx ☐ Refill Rx / Number of Refills	Metric Quantity	Days Supply	MD Name / Prescriber ID No.	Is Rx: No DAW ☐ 0, MD DAW ☐ 1, Patient DAW ☐ 2, RPh DAW ☐ 3, No Generic ☐ 4	Rx Price (including tax) $
Medication Name, Strength, Dosage Form			Is Drug Compound Rx ☐		NDC Number (if compound, include NDCs for all active ingredients)		
3. Rx Number	Date Filled / Prescription Date	Check One ☐ New Rx ☐ Refill Rx / Number of Refills	Metric Quantity	Days Supply	MD Name / Prescriber ID No.	Is Rx: No DAW ☐ 0, MD DAW ☐ 1, Patient DAW ☐ 2, RPh DAW ☐ 3, No Generic ☐ 4	Rx Price (including tax) $
Medication Name, Strength, Dosage Form			Is Drug Compound Rx ☐		NDC Number (if compound, include NDCs for all active ingredients)		

If more than 3 prescriptions, please fill out additional claim forms.

______
Pharmacy Name | Phone No. | Street | City | State | Zip

______ Provider NPI

______ Pharmacist Signature

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 approval of Capital Rx.

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

Prescription Drug Claim Form

Instructions

Policy:

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 of the form for both the patient and policyholder.
4. Sign the form in the area provided.
5. Be sure to include the original pharmacy receipt, cash register receipt and this completed form. Please make copies for your own records.
6. Have your pharmacist complete the bottom section of the form.
7. For a list of participating pharmacies in your area, please refer to our website **www.cap-rx.com**, or call the customer service number on your ID card.
8. Mail completed form to: **Capital Rx, Inc. Atten: Claims Dept., 228 Park Avenue South, Suite 87234, New York, NY 10003**

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 Customer Service at the number on the back of your prescription insurance card.

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.