EmblemHealth™

PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

A. SUBSCRIBER INFORMATION

ID # _____

FOR OFFICE USE ONLY

Claim # _____

Subscriber's Name _____
(Last) (First) (MI)

Street Address _____

City_____ State_____ Zip_____

SUBSCRIBER'S SIGNATURE _____

B. PATIENT INFORMATION

Patient's Name _____
(Last) (First) (MI)

Date of Birth _____ Male ____ Female ____ Patient's ID # _____

Patient's relationship to insured/subscriber: 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 EmblemHealth 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 Address _____City_____ State_____ Zip_____

I certify that the prescription(s) listed below were lawfully dispensed for the above-named patient, information provided is correct and all supporting document is available for audit.

PHARMACIST'S SIGNATURE _____

D1. PRESCRIPTION INFORMATION

Date Dispensed _____ Rx # _____ ☐ ☐ **New or Refill** (Circle One) Name of Medication _____

NDC # _____ Qty Dispensed _____ Days Supply _____ Strength _____

Prescriber's Name _____ Prescriber's State License # _____

Prescription Cost $ _____

D2. PRESCRIPTION INFORMATION

Date Dispensed _____ Rx # _____ ☐ ☐ **New or Refill** (Circle One) Name of Medication _____

NDC # _____ Qty Dispensed _____ Days Supply _____ Strength _____

Prescriber's Name _____ Prescriber's State License # _____

Prescription Cost $ _____

IMPORTANT: SEE REVERSE FOR INSTRUCTIONS

INSTRUCTIONS
PLEASE PRINT ALL SECTIONS

1. This form is to be used to claim prescription drug benefits provided to eligible EmblemHealth subscribers.

2. EmblemHealth subscribers, please complete sections A and B. We need **all** the information requested to process your claims.

3. Copy subscriber's/patient information from your EmblemHealth Identification Card.

4. Have your pharmacist complete sections C, D1 and D2. **Receipts must be attached.**

5. Use a separate form for each patient. In addition, use a separate form for each pharmacy serving the patient.

6. Send the form to: **EmblemHealth Pharmacy Services, 55 Water Street, New York, NY 10041-8190.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.