Please submit claim forms to:
The ODS Companies
Attn: Medical
P.O. Box 40384
Portland, OR 97240-0384

PRESCRIPTION DRUG CLAIM FORM

Group # ______________________

Subscriber ID Number | | | | | | | | | |

Subscriber Name (Please Print) ______ First ______ Middle ______ Last

______ Street ______ City ______ State ______ ZIP Code

Prescriptions were dispensed to:

Patient Name ______ First ______ Middle ______ Last

Patient Birth Date ______ Male ______ Female ______ Relationship to Subscriber (check one) Self ______ Spouse ______ Child ______

Is this medication for an on-the-job injury? Yes ______ No ______

Does this member have prescription coverage under any other group insurance plan? Yes ______ No ______

If yes, provide the name of the insurance company and other employer. ______ Name of Insurance Company

______ Street ______ City ______ State ______ ZIP Code

Note: Use a separate claim form for each covered member of the family.

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Signature ______________________ Patient (or Parent if a Minor)

IF YOU DO NOT HAVE A RECEIPT, PLEASE ASK YOUR PHARMACIST TO COMPLETE THE REMAINING PORTION.
WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION.

Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions		Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number		
Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions		Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number		
Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions		Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number		
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Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number		
Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions		Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number		

Place Pharmacy Label Here or Enter

Pharmacy Name

Street Address

City State ZIP Code

Seven digit NABP Number Required | | | | | | | |

Note: Benefits are payable directly to the covered individual and any assignment of these benefits are void.

Pharmacist's Signature ______________________

Insurance products provided by ODS Health Plan, Inc.