PO Box 40384 Portland, OR 97240-0384

MAJOR MEDICAL PRESCRIPTION CLAIM FORM INSTRUCTIONS

Please use this form if you are required to present your ODS ID card at the pharmacy, pay 100 percent of the discounted rate or submit your receipts for reimbursement under the Medical portion of your plan. If this does not apply to you, please use the Commercial Prescription Claim Form. Using the incorrect claim form may delay payment of your claim.

Please carefully read the following instructions before completing this form. **Claim forms with missing information cannot be processed and will be returned to the sender.**

Part 1: member information (to be completed by the member)

1. Complete all information in Part 1. The member or subscriber ID number is located on your insurance card.
2. A claim must be submitted to ODS within 90 days of the date that the expense was incurred. Under no circumstances will claims submitted later than one year from that date be considered valid, except in the case of legal incapacity.
3. Payment and related correspondence will be sent to the primary subscriber unless you have arranged for an alternate address with ODS.

Part 2: receipt information

1. Submit detailed prescription receipts or labels that contain the requested information (shown below), or have your pharmacy representative complete Part 2 and Part 3. If you do not submit a detailed pharmacy receipt for your prescription(s), a pharmacy representative signature is required.
2. Please photocopy your prescription receipts and submit them with your claim.
   Note: please do not staple receipts or other documentation to the claim form.
3. For compounded medications, please have your pharmacy representative complete Part 3 and the separate compound claim form.
4. Receipts for medication purchased outside the U.S. must be translated into English, including conversion of currency to U.S. dollars. You also must provide the required prescription and pharmacy information as indicated below.

PRESCRIPTION AND PHARMACY INFORMATION

Prescription label example: please use this example as a guide to locate the required information.
Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 123 Any Street Home Town, US 12345-6789	(509) 555-1234 ***Store NPI: 1234567890**
RX 1234567	***Date Filled: 1/1/2009**
***DOE, JANE** ***DOB: 01/01/1900** 456 Home Road Home Town, US 12345	(509) 555-5678
***Amoxicillin 500 mg capsules** (Teva) ***00000-1111-22** ***QTY: 45**	DAW: 0 ***Days Supply: 30**
U&C: 200.00	**COPAY: 20.00**

1. Patient name*
2. Patient date of birth*
3. Date filled*
4. Quantity*
5. Day supply*
6. National drug code (NDC)*
7. Medication name and strength*
8. Usual and customary price (U&C)/RX price*
9. Copay*
10. Pharmacy NPI or NABP number*

****REQUIRED INFORMATION—CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED.***

Part 3: pharmacy information (to be completed by the pharmacy)

1. If required information is not available on the receipt, ask your pharmacy representative to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records.
3. Send the completed form and receipt(s) to: **ODS Medical Claims**
   P.O. Box 40384
   Portland, OR 97240-0384

ODS Alaska

PO Box 40384 Portland, OR 97240-0384

MAJOR MEDICAL PRESCRIPTION CLAIM FORM

PART 1

***Indicates required information**

Primary member/subscriber ID number*	Group number	
Name of health plan/insurance	Primary subscriber name*	Date of birth: (mm/dd/yyyy)* / /
Patient name: (first, middle, last)*	Date of birth: (mm/dd/yyyy)* / /	Relationship to primary subscriber Self ☐ Spouse ☐ Dependent ☐ Domestic partner ☐
Address: (street, city, state, ZIP code)		
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 _____		
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.		
Member signature*	Telephone number ( )	Date

Indicate reason for manually filing these claims (select one)*:

- ☐ Coordination of benefits—claims must be submitted with pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
- ☐ Medicare is primary prescription coverage
- ☐ Discount card was used
- ☐ Health plan/insurance information or insurance card was not available at the time of purchase
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency—please explain _____
- ☐ Worker's compensation
- ☐ Prescription purchased outside the U.S. Please see claim instructions on previous page.
- ☐ Other_____

Manual submission of claims does not guarantee reimbursement.

PART 2

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*		
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* $	Vaccine admin fee $	Copay* $

Is this a compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients and quantity amounts on the Compound Claim Form.)

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*		
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* $	Vaccine admin fee $	Copay* $

Is this a compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients and quantity amounts on the Compound Claim Form.)

PART 3

Affix pharmacy label here or enter the required information:

Pharmacy name*			Pharmacy telephone number	
Street address			NPI or NABP*	
City	State	ZIP	Pharmacy representative signature*	Date*

ODS Alaska

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MAJOR MEDICAL PRESCRIPTION CLAIM FORM

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________		Drug cost* $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________		Drug cost* $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________		Drug cost* $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________		Drug cost* $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________		Drug cost* $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________		Drug cost* $	Copay* $

RX number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*	
Medication name and strength*			Physician name and NPI number Name: ______________________ NPI: ______________________		Drug cost* $	Copay* $

PO Box 40168 Portland, OR. 97240-0168

Prescription Drug Claim Form

For Compounded Prescriptions Only

A completed Part 1 of the Prescription Drug Claim Form and pharmacy receipts* must accompany this Compounded Prescription form.

For Pharmacy use only

- **Enter the NDC number of all legend drugs used.**
- **Indicate the drug ingredient(s) and quantity.**
- **Indicate the metric quantity dispensed in number of tablets, grams, or mls for liquids, creams, ointments, and injectables.**
- **Indicate the amount paid for the prescriptions by the patient.**
- **All plan provisions apply to compounded medications.**

Compounded Prescription Chart			
NDC#	**Drug Ingredient**	**Quantity**	**Charge**
Note: If purchased in a foreign country, the currency must be converted into US dollars.		**Total**	**$**

Affix pharmacy label here or enter the required information:

Pharmacy name*			Pharmacy telephone number	
Street address			NPI*	
City	State	Zip	Pharmacy representative signature*	Date*

***Important:** The original Pharmacy prescription label/receipt (including the required drug information) must accompany this claim form. Please do not highlight receipts or items on this form as this will not show on scanned images and may cause a delay in the processing of your claim. Pharmacy receipts will not be returned, it is recommended that you make copies for your own records.

Send the completed form and receipt(s) to: ODS Prescription Claims

P.O. Box 40168 Portland, OR 97240-0168