Prescription drug claim form

Please read the following instructions carefully before completing this form. Claim forms with missing information cannot be processed and will be returned to the sender. Member information (to be completed by the member)

1. Complete all information in Section 1. The member or subscriber ID number is located on your health plan ID card.
2. A claim must be submitted to Moda Health within 90 days of the date 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. Please submit a separate claim form for each patient and pharmacy from which you purchase medications. Payment and related correspondence will be sent to the primary subscriber unless you have made arrangements with Moda Health to send to an alternate address.

Prescription information

1. Submit detailed prescription receipts or labels that contain the requested information (see example below), or have your pharmacy representative complete Section 2 and Section 3. If you do not submit a detailed prescription receipt for your prescription(s), a pharmacy representative signature is required.
2. Include a copy of your pharmacy receipt(s). Photocopy receipts and submit with the claim form. Note: Please do not staple receipts or other documentation to the claim form.
3. If you have more than one claim, submit a separate Section 2 for each medication or use the multiple prescription alternative form.
4. Receipts for the administration of vaccines require completion of Section 2 and Section 3. A pharmacy representative signature is required.
5. Compounded medications require a separate claim form.
6. Receipts for medication purchased outside the U.S. must be translated into English, including conversion of currency into U.S. dollars. You also must include the required prescription and pharmacy information as indicated in the example below.

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
⑩ Store NPI: 1234567890

RX 1234567
① DOE, JANE
456 Home Road Home Town, US 12345
③ Date Filled: 1/1/2009
② DOB: 01/01/1900
(509) 555-5678

⑦ Amoxicillin 500 mg capsules (Teva) DAW: 0
⑥ NDC #00000-1111-22 ④ QTY: 45 ⑤ Days Supply: 30

⑧ U&C: 200.00 ⑨ COPAY: 20.00

⑪ Dr. Name and Dr. NPI: 1234567890

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*
11. Physician name and NPI number*

**Required information*

Pharmacy information (to be completed by the pharmacy)

1. If required information is not available on the receipt, ask your pharmacy representative to complete Section 2 and Section 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records.

Section 1 › Member information

*Indicates required information

Primary subscriber name*		Group number
Primary member/subscriber ID number*	Subscriber date of birth (mm/dd/yyyy)* ____ / ____ / ______	Group/employer name
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 health plan? ☐ Yes ☐ No If yes, provide the name of the health plan 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* X	Phone	Signature date

Indicate reasons for filing a claim(s) (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 health plan payment)

☐ Medicare is primary prescription coverage

☐ Discount card was used

☐ Health plan, health coverage information or health plan ID 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 ______

Submission of claims does not guarantee reimbursement.

Section 2 › Prescription information
*Indicates required information

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

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

Is this a compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients and quantity amounts on the claim form for compounded prescriptions.)

Section 3 › Pharmacy information
Affix pharmacy label here or enter the required information: *Indicates required information

Pharmacy name*			Pharmacy phone
Address	City	State	Zip
NPI or NABP*	Pharmacy representative signature*		Signature date*

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

Medication name and strength*		Date filled (mm/dd/yyyy)* ______ / ______ / __________	
RX number	☐ New ☐ Refill (check one)	Quantity*	Day supply*
Physician name	National drug code (11-digit)*		
Physician NPI number*	Rx price * $	Vaccine admin fee $	Copay* $

Medication name and strength*		Date filled (mm/dd/yyyy)* ______ / ______ / __________	
RX number	☐ New ☐ Refill (check one)	Quantity*	Day supply*
Physician name	National drug code (11-digit)*		
Physician NPI number*	Rx price* $	Vaccine admin fee $	Copay* $

Medication name and strength*		Date filled (mm/dd/yyyy)* ______ / ______ / __________	
RX number	☐ New ☐ Refill (check one)	Quantity*	Day supply*
Physician name	National drug code (11-digit)*		
Physician NPI number*	Rx price* $	Vaccine admin fee $	Copay* $

Medication name and strength*		Date filled (mm/dd/yyyy)* ______ / ______ / __________	
RX number	☐ New ☐ Refill (check one)	Quantity*	Day supply*
Physician name	National drug code (11-digit)*		
Physician NPI number*	Rx price* $	Vaccine admin fee $	Copay* $

Ready to submit? Mail or fax this form to:
Mail: Moda Health, Attn: Rx Claims Department, P.O. Box 40327, Portland, OR 97240-0327 Fax: 800-207-8235, Attn: Rx Claims Department

modahealth.com