Washington State Rx Services
P.O. Box 40168
Portland, OR 97240-0168

Prescription Drug Claim Form Instructions

Alert! 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.

Part 1: Member information

1. Complete all information in Part 1. The member ID number is located on your health plan ID card.
2. A claim should 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.

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. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.

Part 2: Pharmacy information (to be completed by the pharmacy)

1. If required information is not available on the prescription 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: Washington State Rx Services ATTN: Rx Claims Department
   P.O. Box 40168
   Portland, OR 97240-0168
   Fax: 800-207-8235

Part 3: Receipt information

Please note that a prescription receipt is separate from your pharmacy cash register receipt.
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 prescription receipt for your prescription(s), a pharmacist signature is required.

1. Include a copy of your prescription receipt(s) along with your claim form.
   Note: Please do not staple receipts or other documentation to the claim form.
2. If you have more than one claim, submit a separate Part 3 for each medication or use the multiple prescription form on page 3.
3. Compounded drugs require additional information submitted on the Compound Claim Form (page 5). The pharmacy that filled your prescription may complete this form, or supply the information to you.
4. Receipts for medication purchased outside the U.S. must be translated into English and include conversion of currency into U.S. dollars. You also must include the required prescription and pharmacy information as indicated below.

PRESCRIPTION AND PHARMACY INFORMATION

Prescription receipt/label example: Please use this example for help locating the required information. Note: Each pharmacy may have a unique label format.

Example label	Required information
Anytime Pharmacy #1234 (509) 555-1234 123 Any Street * **Store NPI: 1234567890** Home Town, US 12345-6789 RX 1234567 **(3)Date Filled: 1/1/2009** **(1)DOE, JANE** **(2)DOB: 01/01/1900** 456 Home Road (509) 555-5678 Home Town, US 12345 **(7)Amoxicillin 500 mg capsules (**Teva) DAW: 0 **(6) 00000-1111-22 (4)QTY: 45 (5)Days Supply: 30** **(8)U&C: 200.00 (9)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.***

Prescription Drug Claim Form

PART 1 ***Indicates required information**

Member ID number*	Group number: **10008217**	
Group/employer name: **Uniform Medical Plan**	Primary subscriber name*	Subscriber date of birth: (mm/dd/yyyy)* / /
Member 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 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

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Indicate reasons for filing a claim(s)*:

- ☐ Coordination of benefits other than Medicare—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.

Alert! Non-duplication of benefits ensure that, in total, dependents with dual coverage receive benefits up to what they would have received if Uniform Medical Plan was their only source of coverage (but not in excess of that amount). Non-duplication of benefits does not apply for individuals with Medicare as the primary plan.

PART 2

Affix pharmacy label here or enter the required information:

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

PART 3

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	RX price*	Vaccine admin fee	Copay*
	Name: ______ NPI: ______	$	$	$

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* $

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* $

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

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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 ingredients 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 U.S. 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:

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Washington State Rx Services is administered by **moda HEALTH**