eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Prescription drug claim form

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

Patient and subscriber information (to be completed by the member)

1. Complete all information in Part 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.

Pharmacy information

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

Prescription 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 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 Part 2 for each medication or use the multiple prescription alternative form.
4. Receipts for the administration of vaccines require completion of Part 2 and Part 3. A pharmacy representative signature is required.
5. Compounded medications require a separate Compound Claim Form.
6. Receipts for medication purchased outside the U.S. must be translated into English, including conversion of currency conversion into U.S. dollars. You also must include the required prescription and pharmacy information as indicated below.

Section 1 > Patient and subscriber information (to be completed by the member)

Patient last name*		Patient first name*	Patient M.I.	
Patient date of birth (mm/dd/yyyy)*		Patient address		
Relationship to primary subscriber: ☐ Self ☐ Spouse ☒ Domestic partner ☐ Dependent		City	State	ZIP code
Subscriber last name*		Subcriber first name*	Subscriber M.I.	
Subscriber ID no.*	Group no.	Group/employer name	Subscriber date of birth (mm/dd/yyyy)*	
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 no.	Date (mm/dd/yyyy)	

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.

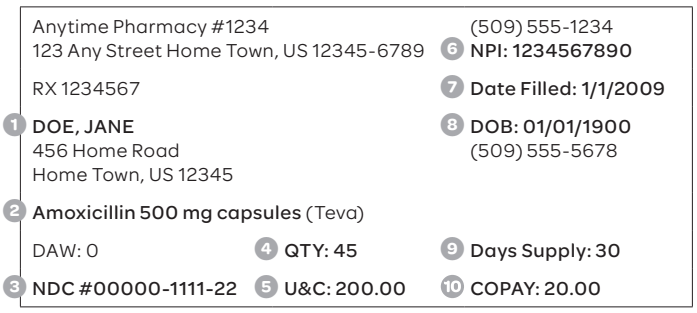
Section 2 › Pharmacy information

Affix pharmacy label here or enter the required information. If the information below is not on the receipt(s) you submit, ask your pharmacy representative to complete and sign.

Pharmacy name*	Pharmacy phone no.	Pharmacy NPI or NABP*	
Pharmacy address	City	State	ZIP Code
Pharmacy representative signature* X		Date (mm/dd/yyyy)*	

Section 3 › Prescription information

If the information below is not on the receipt(s) you submit, ask your pharmacy representative to complete.
Each pharmacy may have a unique label format but please use the sample as a guide to locate the required information.



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

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Is this a compound? ☐ Yes ☐ No

If yes, please identify NDC ingredients and quantity amounts on the Compound Claim Form.

* Indicates required information

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	☐ New prescription ☐ Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

* Indicates required information

Ready to submit? Mail this form to Moda Health, P.O. Box 40168, Portland, OR 97240-0168 or fax to 800-207-8235, ATTN: Rx Claims Department

Questions? Call Moda Health Pharmacy Customer Service at 888-474-8539.

Administered by moda HEALTH

EOCCO nondiscrimination notice

EOCCO complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

EOCCO provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, EOCCO also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

EOCCO Customer Service,
888-788-9821 (TDD/TTY 711)

If you believe that EOCCO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

EOCCO
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone to:

U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

EOCCO efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

注意：如果您說中文，可得到免費語言幫助服務。請致電 1-877-605-3229（聾啞人專用：711）

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION: si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TTY、テレタイプライターをご利用の方は711）までお電話ください。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយ៉ត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

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