Short Term Medical prescription drug claim form

Instructions: *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

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 Short Term Medical 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.

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 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 prescriptions alternative form.
4. Receipts for the administration of vaccines require completion of Part 2.
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.

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 ***DOE, JANE** 456 Home Road Home Town, US 12345	***Date Filled: 1/1/2009** ***DOB: 01/01/1900** (509) 555-5678
***Amoxicillin 500 mg capsules (Teva)** ***NDC #00000-1111-22 * QTY: 45** ***U&C: 200.00**	DAW: 0 ***Days Supply: 30** ***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**

Send the completed form and receipt(s) to:

Moda Health
P.O. Box 40384
Portland, OR 97240

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Part 1 > Member information (to be completed by the member)

**Indicates required information*

Primary member/subscriber ID number*		Group number
Group name: Short Term Medical	Primary subscriber name:*	Subscriber 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 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:*	Telephone number:	Date:

Submission of claims does not guarantee reimbursement.

Part 2 > Receipt information

Please complete required information below and include copy of pharmacy label(s).

Rx number:*	Date filled:*	Check one: ☐ New ☐ Refill	Quantity:*	Day supply:*
Medication name:*	Reason for taking:	Prescribing physician's name:		

Rx number:*	Date filled:*	Check one: ☐ New ☐ Refill	Quantity:*	Day supply:*
Medication name:*	Reason for taking:	Prescribing physician's name:		

Rx number:*	Date filled:*	Check one: ☐ New ☐ Refill	Quantity:*	Day supply:*
Medication name:*	Reason for taking:	Prescribing physician's name:		

Rx number:*	Date filled:*	Check one: ☐ New ☐ Refill	Quantity:*	Day supply:*
Medication name:*	Reason for taking:	Prescribing physician's name:		

Rx number:*	Date filled:*	Check one: ☐ New ☐ Refill	Quantity:*	Day supply:*
Medication name:*	Reason for taking:	Prescribing physician's name:		

Short Term Medical plans provided by Moda Health Plan, Inc.