

Attn: Claims Department, ConnectiCare, P.O. Box 546, Farmington, CT 06034

### Important Instructions:

#### When should you use this form?

- 1) Between the effective date of the prescription program and receipt of your ID card.
- 2) If you are unable to use an In-Network pharmacy. (Note: Your benefit may not allow the use of an Out-of-Network Pharmacy.)
- 3) If you are asked to pay cash for your prescription at a participating pharmacy.

#### Your claim cannot be processed unless this form is complete.

- A separate claim form must be completed for each participant. Complete all information requested under Part A.
- Complete Part B using the information on the packaging of your prescription or receipt, or ask your pharmacist for assistance.
- Tape receipts to an 8.5" x 11" sheet of paper and attach to form.
- Review, sign, and mail completed form with pharmacy receipt(s) to the address at the top of this form.

Note: Pharmacy receipts are required (legible copies are acceptable). Cash register receipts are not accepted.

### Address Information:

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_

### Patient Information:

Does the patient live in a nursing home?  Yes  No

Is this claim for allergy serum?  Yes  No

Did the patient use a network pharmacy?  Yes  No

If no, please give a reason for using an out-of-network pharmacy:

- Drug not available at network pharmacy
- Prescription needed while on vacation
- Emergency
- Other \_\_\_\_\_

## REQUIRED INFORMATION

### Part A (Pharmacy/Prescriber/Participant Information):

Pharmacy NCPDP # \_\_\_\_\_ Pharmacy Name \_\_\_\_\_  
*(ask the pharmacist-7 digits)*

Prescriber DEA # \_\_\_\_\_ Prescriber Name \_\_\_\_\_  
*(ask your doctor-9 digits)*

Participant ID # \_\_\_\_\_ Patient Name \_\_\_\_\_  
*(refer to the front of your ID card)*

Patient Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Patient Gender  male  female

Relationship:  Subscriber  Spouse  Dependent  Other \_\_\_\_\_

### Part B (Prescription Information—contact your pharmacist if you need assistance):

Date Dispensed	Prescription # (RX #)	National Drug Code (11 digit NDC#)	Quantity (QTY)	Days Supply (DS)	Amount Paid

Was this medication covered under any other group insurance plan?  Yes  No

If yes, give name of insurance company and any other employer. \_\_\_\_\_

Also include pharmacy receipts along with explanation of benefits or pharmacy patient profile.

**Authorization:** I certify that they above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, pharmacist, HMO or prepayment organization to supply the Plan Administrator and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

**Participant Signature:**  X  \_\_\_\_\_ **Date:** \_\_\_\_\_

#### Processing Center Use ONLY:

#### PLEASE PROVIDE HIGHLIGHTED INFORMATION AND RESUBMIT.

Claim Form Returned

- Claim Form Required  Send to previous processor, claim dates are prior to effective date with Express Scripts, Inc.  Pharmacy Receipt(s)  Pharmacy NCPDP #
- Pharmacy Name  Dr. DRE #  Dr. Name  Participant ID #  Participant Name  DOB, Gender, Rel. Code  Date Dispensed  Prescription # (RX)
- National Drug Code (NDC)  Quantity (QTY)  Days Supply (DS)  Amount Paid  Explanation of Benefits or Pharmacy Patient Profile-Part B you have indicated that you have primary coverage through another carrier.  Coordination of Benefits (COB) is not an option under your benefit.  Signature  Participant not in system, contact your health plan or employer  The NDC# for the most expensive legend ingredient is required for compound medications  Submit claim(s) to your major medical insurance for processing.  Other \_\_\_\_\_