

DIRECTIONS:

1. Complete and sign claim form below. Use a separate form for each patient.
2. Attach Explanation of Benefits (if applicable) and Prescription Receipts.
3. Send completed Form & Pharmacy receipts to:
PRIME THERAPEUTICS, LLC; P.O. Box 14430; Lexington, KY 40512-4430

I. POLICY HOLDER INFORMATION

This section must be filled out in its entirety for claims to be processed. The Member Number can be found on the front of your ID Card.

POLICY HOLDER NAME (LAST, FIRST, MIDDLE)		MEMBER ID NUMBER H	DATE OF BIRTH (MO, DAY, YR) ____/____/____
GROUP NUMBER			
STREET ADDRESS			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY, STATE, ZIP CODE			

II. PATIENT INFORMATION (Must be completed if patient is a dependent child or spouse)

This section must be filled out in its entirety for dependent claims to be processed.

PATIENT NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH (MO, DAY, YR) ____/____/____	
ADDRESS (If different than member)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> DISABLED DEPENDENT CHILD
CITY, STATE, ZIP CODE			

III. GENERAL INFORMATION

This section must be filled out in its entirety for claims resulting from an accident or claims submitted with other insurance. Attach a copy of the Explanation of Benefits and payment, if applicable.

A. Was condition related to an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO Accident Date ____/____/____ If yes, was it related to: <input type="checkbox"/> Auto Accident <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Other _____	
B. Is other insurance applicable to charge? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete the information below. You must submit an Explanation of Benefits (EOB) for your claim to be processed. Other Carrier Name _____ Policy # _____ Name of Policy Holder _____ Amount Paid By Other Insurance \$ _____	

IV. PHARMACY INFORMATION

The Pharmacy NABP number can be found on the pharmacy receipt, or may be obtained from the pharmacy.

PHARMACY NAME	PHARMACY NABP #	PHONE ()
STREET ADDRESS	CITY, STATE, ZIP CODE	

V. PRESCRIPTION INFORMATION

Prescription receipts are required for processing and each receipt must show:			
• Patient Name	• Pharmacy Name	• Pharmacy Address	• Drug Name and NDC#
• Purchase Date	• Prescription Number	• Total Charge	• Days Supply
If any of your receipts do not have complete information, ask your pharmacist to provide you with the missing information. Write that information on your receipt(s).			• Quantity

VI. CERTIFICATION

The Policy Holder/Patient must sign the Certification section.

I certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge.	
POLICY HOLDER/PATIENT SIGNATURE	DATE