



PO Box 40168 Portland, OR. 97240-0168

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 insurance card.
2. A claim must be submitted to ODS 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 ODS 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 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.

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 RX 1234567 *DOE, JANE *DOB: 01/01/1900 456 Home Road Home Town, US 12345 *Amoxicillin 500 mg capsules (Teva) *00000-1111-22 *QTY: 45 *U&C: 200.00	(509) 555-1234 Store NPI: 1234567890 *Date Filled: 1/1/2009 (509) 555-5678 DAW: 0 *Days Supply: 30 *COPAY: 20.00	<ol style="list-style-type: none"> 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* <p>*REQUIRED INFORMATION—CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED.</p>
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Part 3: pharmacy information (to be completed by the pharmacy)

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.
3. Send the completed form and receipt(s) to: ODS

P.O. Box 40168
 Portland, OR 97240-0168
 Fax: 800-207-8235 ATTN: Rx Claims Department



Prescription Drug Claim Form

PART 1

***Indicates required information**

Primary member/subscriber ID number*		Group number	
Group/employer name		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 <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Domestic partner <input type="checkbox"/>	
Address: (Street, City, State, ZIP code)			
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	

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 insurance payment)

Medicare is primary prescription coverage

Discount card was used

Health plan, insurance information or insurance 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.

PART 2

RX number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)* <table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>													
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$											

Is this a compound? Yes No (If yes, please identify NDC ingredients and quantity amounts on the Compound Claim Form.)

RX number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)* <table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>													
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PART 3

Affix pharmacy label here or enter the required information:

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



Prescription Drug Claim Form

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