

Prescription Claim Form

Follow instructions on reverse side.

Member ID Number: _____ Member Birth Date: _____

 Member Name: _____
 (Please print) First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

 Is this medication for an on-the-job injury? Yes No

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

If yes, provide the name of the insurance company and other employer.

Name of Insurance Company: _____

Note: Use a separate claim form for each covered member of the family.

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.

Signature: _____

Patient (or Parent if a Minor)

★ **Please attach the duplicate pharmacy generated receipt or a copy of a medical expense report from the pharmacy to this form.**
 Cash register receipts are **not** acceptable for any prescriptions.

Please complete the areas below. Incomplete forms will be returned to the Member.

Rx Number 1)	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Directions	Days Supply	Rx Price w/Tax
Medication Name, Form, Strength			DAW	M.D. DEA#	NDC Number (11 digits)	
Rx Number 2)	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Directions	Days Supply	Rx Price w/Tax
Medication Name, Form, Strength			DAW	M.D. DEA#	NDC Number (11 digits)	
Rx Number 3)	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Directions	Days Supply	Rx Price w/Tax
Medication Name, Form, Strength			DAW	M.D. DEA#	NDC Number (11 digits)	
Rx Number 4)	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Directions	Days Supply	Rx Price w/Tax
Medication Name, Form, Strength			DAW	M.D. DEA#	NDC Number (11 digits)	

Pharmacy Name	Pharmacy NABP (Required)
Address	Pharmacy Phone
City	State
Zip	Pharmacist Signature
If the prescription was filled in a foreign country, the currency must be converted into US dollars. Diagnosis and description of the drug is required for processing.	
Note: Pharmacist's signature required when bottom portion of claim form is completed by pharmacy or dispensing facility only.	

For Internal Use Only:

COB Pay in Full

Pay at Contracted Rate

Urgent/Emergent

Researched by _____

Return Completed Form to:
Rocky Mountain Health Plans
Attn: Pharmacy
2775 Crossroads Blvd.
P.O. Box 10600
Grand Junction, CO 81502-5600

INSTRUCTIONS

1. Please complete a separate reimbursement form for EACH FAMILY MEMBER and for EACH PHARMACY used.
2. Please complete all of the information on each drug that you are requesting reimbursement for. Reimbursement will be made to the member for eligible drug charges according to provisions of the member's Health Benefits Contract.
3. Incomplete forms will be returned to member.
4. Please attach proof of purchase pharmacy receipts for all prescriptions listed.

Use these forms when you purchase drugs:

- at a pharmacy that is unable to submit claims electronically
- at a nonparticipating pharmacy

EXPLANATION

Here is an explanation of some of the terms used. The information below should be on the label attached to your prescription or provided by your pharmacist.

1. **Rx Number** — is the number the pharmacy assigns to your prescription (refer to your pharmacy receipt).
2. **Date Filled** — is the date that the pharmacy filled your prescription.
3. **Quantity** — is the amount of medicine you received.
 - a. The number of tablets or capsules.
 - b. For liquids, the number of ml's, cc's, or oz's.
 - c. For creams, ointments, and sprays, the number of grams or oz's.
4. **Strength** — a drug may be available in more than one strength, and this helps to identify the specific medicine you received (refer to your pharmacy receipt). It will be measured by:
 - a. mg (i.e., Tagamet 300 mg)
 - b. % (i.e., Timoptic 0.5%)
5. **NDC No.** — is a national code number used to identify each individual medication.
6. **NABP** — National Pharmacy code used to identify each individual pharmacy.
7. **Day Supply** — how many days the prescription will last.

If you have any questions, be sure to ask the pharmacist.

If you need help or to obtain additional forms, please call Rocky Mountain Health Plans Customer Service.

Individual Members and Group Plan Members (Para asistencia en español llame al)970-243-7050 or 800-346-4643

Medicaid Members (Para asistencia en español llame al)970-244-7860 or 888-282-8801

Rocky Mountain Health Plans
2775 Crossroads Blvd.
P.O. Box 10600
Grand Junction, CO 81502-5600

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.