



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"> <li>1. Patient name*</li> <li>2. Patient date of birth*</li> <li>3. Date filled*</li> <li>4. Quantity*</li> <li>5. Day supply*</li> <li>6. National drug code (NDC)*</li> <li>7. Medication name and strength*</li> <li>8. Usual and customary price (U&amp;C)/RX price*</li> <li>9. Copay*</li> <li>10. Pharmacy NPI or NABP number*</li> </ol> <p><b>*REQUIRED INFORMATION—CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED.</b></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



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# 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)			
Does this member have prescription coverage under any other group insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide the name of the insurance company and other employer _____			
<b>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.</b>			
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)*  _ _ _ _ _ _ _ _ _ _ _ _		
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)*  _ _ _ _ _ _ _ _ _ _ _ _		
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.)

## PART 3

Affix pharmacy label here or enter the required information:

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



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## Prescription Drug Claim Form

RX number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)*  _ _ _ _ _ _ _ _ _ _ _ _		
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$

RX number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)*  _ _ _ _ _ _ _ _ _ _ _ _		
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$

RX number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)*  _ _ _ _ _ _ _ _ _ _ _ _		
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$

RX number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)*  _ _ _ _ _ _ _ _ _ _ _ _		
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$

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Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$

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Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$

RX number	Date filled* / /	New <input type="checkbox"/> Refill <input type="checkbox"/> (check one)	Quantity*	Day supply*	National drug code (11-digit)*  _ _ _ _ _ _ _ _ _ _ _ _		
Medication name and strength*			Physician name and NPI number Name: _____ NPI: _____		RX price* \$	Vaccine admin fee \$	Copay* \$



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## Prescription Drug Claim Form

### For Compounded Prescriptions Only

A completed Part 1 of the Prescription Drug Claim Form and pharmacy receipts\* must accompany this Compounded Prescription form.

#### For Pharmacy use only

- Enter the NDC number of all legend drugs used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the metric quantity dispensed in number of tablets, grams, or mls for liquids, creams, ointments, and injectables.
- Indicate the amount paid for the prescriptions by the patient.
- All plan provisions apply to compounded medications.

#### Compounded Prescription Chart

NDC#	Drug Ingredient	Quantity	Charge
<b>Note: If purchased in a foreign country, the currency must be converted into US dollars.</b>		<b>Total</b>	<b>\$</b>

Affix pharmacy label here or enter the required information:

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

**\*Important:** The original Pharmacy prescription label/receipt (including the required drug information) must accompany this claim form. Please do not highlight receipts or items on this form as this will not show on scanned images and may cause a delay in the processing of your claim. Pharmacy receipts will not be returned, it is recommended that you make copies for your own records.

Send the completed form and receipt(s) to: ODS Prescription Claims

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