CLEARSCRIPT Direct Reimbursement Claim-ClearScript

PART ONE: To be completed by you

MEMBER ID

PATIENT NAME

0	6	8	1	0	0	0	0

CUSTOMER ID

PATIENT'S DATE OF BIRTH (MM/DD/YY)

MEMBER NAME

SEX: ☐ MALE ☐ FEMALE

RELATIONSHIP:

☐ SUBSCRIBER ☐ SPOUSE ☐ CHILD

☐ OTHER:_____

EXPLAIN RELATIONSHIP

MAIL ADDRESS – STREET

CITY STATE ZIP

DAYTIME TELEPHONE

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for the treatment of an on-the-job injury, or covered under another benefit plan unless Part Two is completed. I authorize release of all information pertaining to this claim to Argus Health Systems, Inc., the plan administrator, insurance underwriter, plan sponsor, policyholder, and/or employer. I certify that all the information entered on this form is correct.

X

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: Coordination of Benefits (COB)*: To be completed by you

YOUR POLICY/PLAN MUST HAVE A PHARMACY COB CLAUSE IN ORDER TO COORDINATE BENEFITS.

HAS YOUR CLAIM BEEN PROCESSED WITH ANOTHER INSURANCE CARRIER?

☐ NO If no, you can skip the remainder of Part Two.

☐ YES If yes, attach a **copy** of: your explanation of benefits (EOB) or statement from the other coverage and/or your receipt from the pharmacy.

NAME OF INSURED POLICYHOLDER

NAME OF INSURED'S EMPLOYER

NAME OF OTHER INSURANCE COMPANY

POLICY NUMBER (OTHER INSURANCE COMPANY)

TYPE OF COVERAGE ☐ SINGLE ☐ FAMILY

PRESCRIPTION #1	PRESCRIPTION #2
Tape Pharmacy Receipt Here Cash register receipts are not acceptable	Tape Pharmacy Receipt Here Cash register receipts are not acceptable

PART THREE: Pharmacy Information - To be completed by you or your pharmacist

PHARMACY NAME

ADDRESS – STREET

NCPDP ID

CITY STATE ZIP

PHARMACY TELEPHONE

FOR COMPOUNDS

For Compounds: Pharmacist must identify the specific prescription by date of service and Rx number. Please list name, National Drug Code (NDC) # and metric quantities of each ingredient in box on left.

X

SIGNATURE OF PHARMACIST FOR COMPOUNDS

CLEARSCRIPT Direct Reimbursement Claim-ClearScript

HOW TO COMPLETE THIS FORM

Complete the following (please use a separate claim form for each family member)

Note: Claim submission is not a guarantee of payment.

PART ONE

Subscriber Information

1. Member ID: The Member ID copied exactly from the ID Card.
2. Member name, address, and telephone number.
3. Patient Name: Person for whom the drug was prescribed.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female
6. Status: Patient's relationship to subscriber. If other, please write in the type of relationship.

PART TWO

Coordination of Benefits (COB)

1. If you **do not** have Coordination of Benefits (COB) coverage, check No.
2. If you **do** have COB coverage, check Yes, complete Part Two, and attach a **copy** of: Explanation of Benefits (EOB) or statement from other coverage and/or pharmacy receipt.
3. Name of insured policyholder.
4. Name of insured individual's employer.
5. Name of other insurance company.
6. Insurance policy number from other insurance company.

PART THREE

Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. National Council for Prescription Drug Program (NCPDP) ID: Obtain the number from the pharmacy where prescriptions were purchased.
3. Tape pharmacy receipts to the form in the space provided. The receipts must indicate **date of service**, **Rx number**, **NDC number**, **quantity**, **days' supply** and the **amount paid**. Cash register receipts are not acceptable for any prescriptions.
4. Use a separate claim form for each pharmacy from which you purchase prescriptions.

MAIL THIS FORM TO

SS&C Health
Dept: 0681
PO Box 419019
Kansas City, MO 64141