Prescription Drug Claim Form

Please mail this form and all original prescription receipts to:
True Rx Health Strategists Attn: Claims
P.O. Box 431 Washington, IN 47501 (866) 921-4047 (812) 254-7426 fax

Each Pharmacy Receipt Must Show:

- Participant Name
- Prescription (Rx) Number
- Pharmacy Name & Address or NPI Number
- Drug Name/Strength & NDC Number
- Metric Quantity and Days Supply
- Dispense as written (DAW), if applicable
- Physician Name or NPI Number
- Purchase Date
- Amount Member Paid

The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

*Please use a separate claim form for each covered member of the family.

Number of Receipts:_____ **Was the prescription obtained while traveling/residing outside the United States? ___Yes ___No**

Section A: Cardholder Information

Primary Cardholder ID# **(required)**_____ Plan/Group ID #:_____

Cardholder Last Name:_____ Plan Sponsor/Employer:_____

Cardholder First Name:_____ Daytime Phone Number:_____

Mailing Address:_____

City :_____ State :_____ Zip:_____

Section B: Patient Information

Patient Last Name:_____ Date of Birth:_____

Patient First Name:_____ Gender: ___M ___F

Patient's Relationship to Cardholder: ___Self ___Spouse ___Son ___Daughter
___Widow ___Full Time Student ___Sponsored Dependent/Other

Section C: COB (Coordinaton of Benefits)

Is the medicine covered under any other group insurance? ___Y ___N If yes, is other coverage: ___Primary ___Secondary

If other coverage is Primary, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:_____ ID #:_____

Section D: Reason for Claim or Special Notes

Section E: Signature Required

FRAUD PREVENTION REGULATION: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

RELEASE OF INFORMATION: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury. I have indicated in the COB box above if there is primary prescription drug coverage under another medical plan. I authorize release of all information pertaining to this claim to True Rx, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

Signature of Cardholder **Date**

Revised 01.2021