

PRESCRIPTION DRUG CLAIM FORM



MEMBER INFORMATION

Complete this section using the information on your ID Card

AMERIRX

PAID NUMBER

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IDENTIFICATION NUMBER

MEMBER NAME

ADDRESS

CITY

STATE

ZIP

TELEPHONE

Is This Medication Covered Under Any Other Group Insurance
YES NO

The undersigned certifies that the medication(s) described hereon was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the undersigned's family members. The undersigned further authorizes use of such person's social security number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

SIGNATURE OF PATIENT OR GUARDIAN OR LEGAL REPRESENTATIVE

X _____

PHARMACY INFORMATION—(Pharmacy Number Required)

PHARMACY NAME

TELEPHONE NUMBER

ADDRESS

PAID PHARMACY ACCOUNT NUMBER / NABP

CITY

STATE

ZIP

PRESCRIPTION INFORMATION—Pharmacist must complete all shaded areas. Member must complete all other areas.

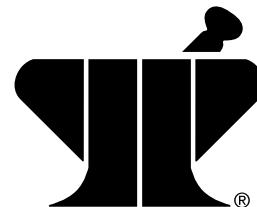
Rx 1	PATIENT NAME				PATIENT SOC. SEC. NUMBER				OFFICE USE									
	PATIENT D.O.B. (MM/DD/YY) / /		MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		STATUS: MEMBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				OV CODE									
	DATE FILLED (MM/DD/YY)	Rx NUMBER	NEW <input type="checkbox"/> REFILL <input type="checkbox"/>		DRUG NAME/STRENGTH (If compound, see below*)				INITIAL									
	/ /				NDC NUMBER													
METRIC QUANTITY	DAYS SUPPLY	D.A.W.	PHYSICIAN I.D. NUMBER				TOTAL PRESCRIPTION CHARGE											
Rx 2	PATIENT NAME				PATIENT SOC. SEC. NUMBER				OFFICE USE									
	PATIENT D.O.B. (MM/DD/YY) / /		MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		STATUS: MEMBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				OV CODE									
	DATE FILLED (MM/DD/YY)	Rx NUMBER	NEW <input type="checkbox"/> REFILL <input type="checkbox"/>		DRUG NAME/STRENGTH (If compound, see below*)				INITIAL									
	/ /				NDC NUMBER													
METRIC QUANTITY	DAYS SUPPLY	D.A.W.	PHYSICIAN I.D. NUMBER				TOTAL PRESCRIPTION CHARGE											
Rx 3	PATIENT NAME				PATIENT SOC. SEC. NUMBER				OFFICE USE									
	PATIENT D.O.B. (MM/DD/YY) / /		MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		STATUS: MEMBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				OV CODE									
	DATE FILLED (MM/DD/YY)	Rx NUMBER	NEW <input type="checkbox"/> REFILL <input type="checkbox"/>		DRUG NAME/STRENGTH (If compound, see below*)				INITIAL									
	/ /				NDC NUMBER													
METRIC QUANTITY	DAYS SUPPLY	D.A.W.	PHYSICIAN I.D. NUMBER				TOTAL PRESCRIPTION CHARGE											
Rx 4	PATIENT NAME				PATIENT SOC. SEC. NUMBER				OFFICE USE									
	PATIENT D.O.B. (MM/DD/YY) / /		MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		STATUS: MEMBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				OV CODE									
	DATE FILLED (MM/DD/YY)	Rx NUMBER	NEW <input type="checkbox"/> REFILL <input type="checkbox"/>		DRUG NAME/STRENGTH (If compound, see below*)				INITIAL									
	/ /				NDC NUMBER													
METRIC QUANTITY	DAYS SUPPLY	D.A.W.	PHYSICIAN I.D. NUMBER				TOTAL PRESCRIPTION CHARGE											

***Pharmacist**—If the drug prescribed above is a compound, please list all ingredients and quantities:

Rx NUMBER:

I hereby certify that the charge(s) shown for the medications prescribed is/are correct, and agree to provide PAID Prescriptions or its agents reasonable access to records related to medications(s) dispensed to this patient(s) in accordance with applicable law. I further recognize that reimbursement will be paid directly to the member and any assignment of these benefits to a pharmacy or otherwise is void.

X _____
PHARMACIST'S SIGNATURE



PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS

This is a sample PRESCRIPTION Card. PLEASE WAIT UNTIL YOU RECEIVE YOUR PRESCRIPTION I.D. CARD BEFORE SENDING THIS CLAIM TO PAID. CLAIMS WITHOUT THE PROPER IDENTIFICATION NUMBERS FROM YOUR CARD WILL NOT BE PROCESSED. To avoid undue delay, please complete all required areas of information on the claim form.

**12-Digit
Member I.D. Number**

AMERIHEALTH

<p>A. MEMBER MEMBER I.D. NO. Q1S123456789</p>	<p>GROUP NO. 12345</p>
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SEH (PPO, CMM)
Rx PAID GROUP: AMERIRX

Please be sure to copy the identification number exactly as it appears on the plastic card. If this is not done, the claim form will be returned to you.

The MEMBER I.D. NUMBER must have 12 digits.

Member Information

1. Identification Number: Copy from the plastic card.
2. Member name, address, and telephone number.
3. Dual Coverage: Certification that this claim is not covered by another insurance carrier.

Pharmacy Information

4. Pharmacy name, address, and telephone number where prescriptions were purchased.
5. PAID Pharmacy Account Number: 9 digit account number assigned to the pharmacy where prescriptions were purchased; or pharmacy NABP Number.

Member Information

(To be completed by Member):

6. Patient Name: Person drug was prescribed for.
7. Patient Social Security Number.
8. Patient Date of Birth: Month, Day, Year.
9. Patient Sex: Check Male or Female.
10. Status: Patient's relationship to member. If other, please write in type of relation.

Prescription Information

(To be completed by Pharmacist):

11. Date Filled: Date prescription was purchased.
12. Rx Number: Prescription number.
13. New, Refill: Check if initial or subsequent filling of prescription.
14. Drug Name/Strength: Name of drug prescribed and dosage.
15. N.D.C. Number: National Drug Code Number assigned to drug prescribed.
16. Metric Quantity: Amount of drug dispensed (Example: Number of pills).
17. Days Supply: Number of days the prescription will fulfill.
18. D.A.W.: Dispense as written indicator: 0=no DAW, 1=physician DAW, 2=patient DAW, 3=pharmacy DAW, 4=no generic available, 5=other.
19. Physician Identification Number: 10 digit number assigned to the physician who prescribed the prescription.
20. Total Prescription Charge: Dollar amount paid for the prescription.

General Information

- The direct reimbursement claim is to be used in the absence of the AmeriHealth I.D. card or when the card is not accepted by the pharmacy.
- The claim form may be used for all persons covered under the member's benefit. For example: prescriptions for a member, spouse, and covered child may be on the same form. For each prescription THE PATIENT NAME, DATE OF BIRTH, SEX, AND STATUS MUST BE COMPLETED.
- The claim form is valid for one pharmacy only. If more than one pharmacy is used, a separate claim form must be used for each pharmacy.
- Receipts are required to be submitted with the claim form in order to verify information provided on the claim form. FAILURE TO SUBMIT PRESCRIPTION RECEIPTS MAY RESULT IN NON-PAYMENT OF CLAIMS.
- All information on the claim form must be typed or printed. LABELS OR COMPUTER PRINTOUTS FROM THE PHARMACY WILL NOT BE ACCEPTABLE. THESE CLAIMS WILL BE RETURNED FOR COMPLETION.
- Please submit completed form to:

PAID Prescriptions, L.L.C.
 P.O. Box 727
 Parsippany, New Jersey 07054-0727
 1-800-272-7243