Pharmacy Claim Form

PATIENT INFORMATION

Patient name: _____ Date of birth: _____ dd / mm / yyyy

Address: _____ Phone number: _____

Email address: _____ Insurance ID number: _____

Group number (if applicable): _____

PHARMACY INFORMATION

Pharmacy name: _____ Address: _____

Phone number: _____ License number: _____

PRESCRIPTION INFORMATION

Date of service: _____ dd / mm / yyyy Prescription number: _____

Medication name: _____ Strength: _____

Quantity: _____ Days supply: _____

Prescribing physician: _____ Phone number: _____

National drug code: _____

CLAIM INFORMATION

Total amount paid: _____ Copay amount: _____

Amount to be reimbursed: _____

Reason for claim submission:

◯ Medication not covered ◯ Out-of-network-pharmacy ◯ Other

SIGNATURE

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that the submission of this claim is subject to verification.

Patient's signature:

Date: _____ dd / mm / yyyy