DIRECT PRESCRIPTION DRUG REIMBURSEMENT

PNPS
Preferred National Pharmacy Solutions

P.O. Box 5300
Poland, OH 44514
800.571.6031

EMPLOYEE MUST COMPLETE THIS SIDE PLEASE PRINT

The undersigned certifies that the medication described hereon was received for the named person who is eligible for drug benefits, and that this medication is not for an on-the-job injury of a covered benefit by other insurance. The undersigned authorizes release of all information contained hereon to Preferred National Pharmacy Solutions, or its agents, to sponsors, carriers, or health providers, and further authorizes use of member' s social security number as the identification.

SIGNATURE OF PATIENT OR GUARDIAN OR LEGAL REPRESENTATIVE X

DRUG CARD INFORMATION

GROUP NUMBER	MEMBER ID NUMBER

PATIENT IS:
☐ MALE ☐ SPOUSE
☐ FEMALE ☐ CHILD
☐ EMPLOYEE

PATIENT 'S FIRST NAME | BIRTH DATE

BILL AS A COORDINATION OF BENEFIT (COB) CLAIM ONLY. ☐ YES

PRINT

CARDHOLDER NAME FIRST INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

THIS CLAIM MUST BE FILED WITHIN ONE (1) YEAR OF PURCHASE DATE

PHARMACY LABEL OR FULL NAME AND ADDRESS

PHARMACY INFO MUST BE COMPLETED ON THIS SIDE PLEASE PRINT

CLAIM NUMBER
X

PHARMACY ACCOUNT NUMBER

DATE OF THIS SERVICE

PRESCRIPTION NUMBER

METRIC QUANTITY DISPENSED CC TABS GM CAPS

1 ☐ NEW
2 ☐ REFILL

DAYS SUPPLY

NDC

PRINT

DRUG NAME STRENGTH

TOTAL Rx CHARGES

MANUFACTURER ' S NAME

PLAN PAID AMT: $

PRESCRIBER ' S DEA NUMBER

CIRCLE ONE
MD DO DDS POD

MEMBER PAID AMT: $

PHARMACIST ' S SIGNATURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

PLEASE MAIL THIS FORM AND YOUR RECEIPT TO: PREFERRED NATIONAL PHARMACY SOLUTIONS P.O. BOX 5300 POLAND, OH 44514