

DIRECT PRESCRIPTION DRUG REIMBURSEMENT



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 | | | | PATIENT IS: | |
|---|------------------|------------|--|-----------------------------------|---------------------------------|
| GROUP NUMBER | MEMBER ID NUMBER | | | <input type="checkbox"/> MALE | <input type="checkbox"/> SPOUSE |
| | | | | <input type="checkbox"/> FEMALE | <input type="checkbox"/> CHILD |
| | | | | <input type="checkbox"/> EMPLOYEE | |
| PATIENT'S FIRST NAME | | BIRTH DATE | BILL AS A COORDINATION OF BENEFIT (COB) CLAIM ONLY. <input type="checkbox"/> YES | | |
| P R I N T | 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 <input type="checkbox"/> NEW | DAYS SUPPLY | | | | | | | | | | |
| | 2 <input type="checkbox"/> REFILL | | | | | | | | | | | |
| N D C | <table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> | | | | | | | | | | | |
| | | | | | | | | | | | | |
| P R I N T | 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.

