Cardholder - patient information.

Employer Name	Group Name	Group Number (from ID Card)

Cardholder Name (Last Name, First Name, M.I.)	Cardholder Identification NO. (from ID Card)	Member Email Address

Patient Name (Last Name, First Name, M.I.)	Patient's Sex	Relationship of Patient to Cardholder:		Date of Birth		
	Male ☐	Self ☐	Child ☐	Month	Day	Year
	Female ☐	Spouse ☐	Other ☐			

Mailing Address of Cardholder (Number and Street)	City	State	Zip Code

I certify that the patient for whom this claim is made is a covered person in this benefit program and that these prescriptions are for the sole use of the named patient.
I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation program.

(Cardholder/Authorized Representative Signature): X Telephone No: ( )

Prescription information.

Claim Number	For Office Use Only	Rx Number	Date Filled	New Rx	Refill Rx	Name of Drugs/Strength/Dosage Form (If generic, include manufacturer, if compounded Rx complete reverse side)
National Drug Code: Manufacturer / Product No. / Pkg.			Metric Qty. Dispensed	Metric Qty. Dispensed	Name Of Prescribing Physician Or Identification Number (i.e. DEA No./NPI)	Prescription Price (including all discounts) $

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Claim Number	For Office Use Only	Rx Number	Date Filled	New Rx	Refill Rx	Name of Drugs/Strength/Dosage Form (If generic, include manufacturer, if compounded Rx complete reverse side)
National Drug Code: Manufacturer / Product No. / Pkg.			Metric Qty. Dispensed	Metric Qty. Dispensed	Name Of Prescribing Physician Or Identification Number (i.e. DEA No./NPI)	Prescription Price (including all discounts) $

COMPOUNDED PRESCRIPTION CLAIM

Claim Number	For Office Use Only	Rx Number	Date Filled	New Rx	Refill Rx	Compounded Ingredients / Quantities
National Drug Code: Manufacturer / Product No. / Pkg.			Metric Qty. Dispensed	Metric Qty. Dispensed	Name Of Prescribing Physician Or Identification Number (i.e. DEA No./NPI)	Prescription Price (including all discounts) $

Pharmacy information.

Name, Address & Telephone Number of Pharmacy	N.A.B.P. Pharmacy Identification Number	I certify that the charge shown is for the drug(s) dispensed to this recipient. (Signature and License No. of Pharmacist requested)

Form ROI00051 Rev. 5-3-2013

PLEASE READ INSTRUCTIONS ON REVERSE SIDE.

Instructions.

A. When to Use This Form

1. This claim form is to be used only when it has been necessary to purchase prescriptions because your participating pharmacy did not honor your identification card or was unable to directly submit your claim. It should also be used when it was necessary to have your prescriptions filled at a non-participating pharmacy.
2. Submit this form to the address below as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to keep the form until completely filled.

B. How to Complete This Form

1. Complete the upper portion of the claim form under **Cardholder Information**. Transfer the Cardholder Identification Number, Member Number (if applicable) and Group Number from your identification card.
2. A separate claim form must be completed for each **patient**.
3. Have your pharmacist complete the **Prescription Information** section for each prescription filled and the **Pharmacy Information** section. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or your receipt.

   Important: The drug quantity, drug name and strength **or** eleven digit National Drug Code (NDC) is required and **must** appear on your submitted claim(s) or receipt(s).
4. **The original paid pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory proof of purchase.**
5. **For Compounded Prescriptions Only:** If your pharmacist tells you this is a compounded prescription, you must complete CLAIM NUMBER 6. Ask your pharmacist for assistance. The NDC number appearing on the claim should be that of the most expensive prescription ingredient. Should you have more than one compounded prescription, please use additional claim forms. Or, have the compounding pharmacy submit the charges on their claim form.
6. Claim forms submitted without the required information can cause payment delays and result in the information being returned for completion.

C. Where to Send This Form

1. Mail, email or fax this form and your original paid pharmacy receipt(s)to:

   MedImpact
   PO Box 3047
   North Canton, OH 44720

   Fax: (866) 552-8939 **keyedclaims@elixirsolutions.com**
2. Please allow eight weeks for processing and payment of your claims.
3. You may call 1-800-771-4648 between 8:00 AM and 9:00 PM (Central Time) for questions or problems concerning your submitted claims.

CLAIMS WITH MISSING OR ILLEGIBLE INFORMATION WILL BE RETURNED.