Prescription Drug Claim Form

PARTICIPANT/PATIENT INFORMATION	
Participant Name:	
(from SHIP card) Group #	Member #:
Daytime Phone:	Alternative Phone:
Patient Name (*use a separate form for each family member*):	
Patient Relationship to Participant (check one): ☐ Self ☐ Spouse/Partner ☐ Dependent Child	
Patient Sex: ☐ Female ☐ Male	Patient Date of Birth (mm/dd/yyyy):
(from SHIP card) Group #	Member #:

PRESCRIPTION INFORMATION	
For Health Care Reform-related Over-the-Counter reimbursement requests, include your Doctor's prescription.	
1. _____ _____ _____ _____ Date Filled RX Number QTY Day Supply _____ _____ $_____ Drug Name & Strength NDC Amt. Paid _____ _____ Pharmacy Name Pharmacy NABP _____ Pharmacy Address	2. _____ _____ _____ _____ Date Filled RX Number QTY Day Supply _____ _____ $_____ Drug Name & Strength NDC Amt. Paid _____ _____ Pharmacy Name Pharmacy NABP _____ Pharmacy Address

INSTRUCTIONS

PARTICIPANT/PATIENT INFORMATION *(To be completed by the Participant)*

1. Complete ALL information above.
2. Submit a separate form for EACH family member.
3. The Prescription Information section must be completed for each prescription for which you are seeking reimbursement. If you need help completing this form, contact your pharmacist. For Health Care Reform-related Over-the-Counter reimbursement requests, include your Doctor's prescription. Please retain a copy of the prescription for your records.
4. **Keep a copy for your records.**
5. Mail this form within 12 months of the prescription fill date, along with original receipts (cash register receipts are not acceptable) to:

   Consolidated Health Plans
   2077 Roosevelt Ave.
   Springfield, MA 01104
6. Questions? Please call Consolidated Health Plans at (800) 633-7867.