# Prescription Drug Claim Form

| PARTICIPANT/PATIENT INFORMATION | | | |
|---|---|---|---|
| Participant Name: | | | |
| (from ID card) Group #: | | Member #: | |
| Daytime Phone: | | Alternative Phone: | |
| Patient Name: | | | |
| Patient Relationship to Participant *(check one)*:<br>☐ Self ☐ Spouse/Partner ☐ Dependent Child | | | |
| Patient Sex: ☐ Female ☐ Male | | | |
| Patient Date of Birth *(mm/dd/yyyy)*: | | | |
| **PRESCRIPTION INFORMATION** | | | |
| ***For Health Care Reform-related Over-the-Counter reimbursement requests, include your Doctor's prescription.*** | | | |
| **Prescription 1** | | | |
| **Date Filled:** | **Rx Number:** | **Quantity:** | **Day Supply:** |
| **Drug Name & Strength:** | | | |
| **Amount Paid: $** | | | |
| **Pharmacy Name:** | | | |
| **Pharmacy Address:** | | | |
| **Prescription 2** | | | |
| **Date Filled:** | **Rx Number:** | **Quantity:** | **Day Supply:** |
| **Drug Name & Strength:** | | | |
| **Amount Paid: $** | | | |
| **Pharmacy Name:** | | | |
| **Pharmacy Address:** | | | |

# INSTRUCTIONS

To be completed by the Participant

1. Complete ALL information on page 1.
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 the 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. Submit either prescription receipts/labels with this claim form or a patient history print-out from your pharmacy.
5. Mail or email this form within 12 months of the prescription fill date, along with original receipts (cash register receipts are not acceptable unless over the counter) to:

    Consolidated Health Plans

    2077 Roosevelt Ave.

    Springfield, MA 01104

    prescription@consolidatedhealthplan.com

**For questions please call Consolidated Health Plans at 877-657-5030