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Unified Labor Rx Prescription Drug Claim Form

UNIFIED LABOR RX

Instructions for completing Prescription Drug Claim Form:

- Complete all sections of the claim form below.
- Submit a completed Universal Compound Form, in addition to this form, for compound reimbursement requests.
- Copies of pharmacy receipts and register receipts must be included with submitted claim form.
- The pharmacy receipts must show the following prescription information for each expense:
  - Pharmacy Name and Address
  - Patient Name
  - Amount Paid Out-of-Pocket
  - Prescription Number and Fill Date
  - Prescriber Name
  - Drug Cost
  - Drug Name, Strength, and NDC
  - Quantity and Days-Supply
- Mail or fax the completed form and accompanying receipts to:
  Prime Therapeutics
  Attn: CP – 4102
  P.O. Box 64811
  St. Paul, MN 55164-0811
  Fax: 1-888-656-3607
- If you have any questions, please call your Customer Service area.

Note: This claim will not be processed until this form and accompanying receipts are submitted.

1. Policyholder or Insured Name (First, Middle, Last): _____

   Address: _____

   City: _____ State: _____ Zip Code: _____
2. Policyholder or insured ID No. (as shown on ID Card): _____
3. Why was the insurance or drug card not used for this purchase?

   _____
4. Patient's Name (First, Middle, Last): _____
5. Patient's Birth Date: _____
6. Patient's Relationship to Policyholder:

   ☐ Self ☐ Spouse ☐ Dependent ☐ Other
7. Is the patient eligible for any other Prescription Drug Coverage?

   ☐ No ☐ Yes If **yes**, complete the following:

   Does the coverage include: ☐ Major Medical ☐ Drug ☐ Other Medical

   Insured's Name: _____ Insured's ID Number: _____

   Insured's Birth Date: _____ Effective Date: _____

   Insurance Company Name: _____

   Insurance Company Address (Street, City, State, Zip Code):

   _____

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Prime Therapeutics, its agents, or representatives.

Signature: _____ **Date:** _____

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