Prescription Drug Claim Form

St Luke's Health Plan

Policyholder Information *(Please reference your member ID card)*

First Name: _____ Last Name: _____

Date of Birth: _____ Member ID: _____ Group Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Plan or Employer Name: _____

Patient Information *(If different than the policyholder)*

First Name: _____ Last Name: _____

Date of Birth: _____ Member ID: _____ Group Number: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Relationship to Policyholder: ☐ Spouse ☐ Dependent

Reason for Reimbursement Request *(Make all applicable selections)*

- ☐ Didn't have access to my prescription ID card *(complete section 1 below)*
- ☐ Purchased from an out-of-network pharmacy due to: *(select below and complete section 1)*
  - ☐ Illness after traveling
  - ☐ Vaccine received at my doctor's office
  - ☐ No network pharmacy
  - ☐ Federal emergency/natural disaster
  - ☐ Medication out of stock
- ☐ Purchased while waiting for an approval (*complete section 1 below)*
- ☐ Pharmacy billed the incorrect insurance plan (*complete section 1 below)*
- ☐ Purchased a compound prescription (*complete sections 1 and 2 below)*
- ☐ Coordination of benefits (*complete sections 1 and 3 below)*
- ☐ Received a vaccine administered in an outpatient setting (*complete sections 1 and 4 below)*
- ☐ Other: _____

Section 1: Standard Reimbursement Information

Pharmacy/Supplier Information

Pharmacy Name: _____ Pharmacy NPI: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Prescriber Information

Name: _____ NPI Number: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Purchased Prescription/Vaccine/Equipment Information

Purchased/Fill Date: _____ NPI Number: _____ Total Paid: _____

Drug Name: _____ NDC/UPC: _____ Admin Fee: _____

Section 2: Compound Prescriptions Only

Rx Number: _____ Day Supply: _____

Valid 11-digit Ingredient NDC:	Quantity	Ingredient Cost
Total Quantity		
Total Charge		

Section 3: Coordination of Benefits Reimbursement Requests

Is this information for an on-the-job inquiry? ☐ Yes ☐ No

Is this medication covered under any other group insurance plan? ☐ Yes ☐ No

If yes, provide the following information for the other insurance:

Employer/Insurance Name: _____ ID Number: _____ Phone Number: _____

Attach the primary carrier's explanation of benefits (EOB), original receipts, and prescription information from your prescription bag to this completed and signed claim form.

Section 4: Vaccine Information

Is this a two-part vaccine? (i.e. Shingrix) ☐ Yes ☐ No

If yes, is this vaccine: ☐ First part in a series ☐ Second part in a series

Administered location: ☐ Physician Office ☐ Clinic ☐ Pharmacy

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 Capital Rx. Any assignment of these benefits must include an appropriate signature and is subject to Capital Rx's approval.

Signature _____ Date _____

Patient or Authorized Representative

Please note: *If you are preparing this form on behalf of a member, please include a completed Personal Health Information Disclosure Form. For Medicare Part D members, please include a completed CMS- 1696 form (Appointment of Representative form) or Personal Health Information Disclosure Form. Per CMS regulations, a purported representative may submit a completed CMS-1696 form or a form that includes the same information as the CMS-1696 form. Blank forms are available by visiting https://www.cap-rx.com/members#member-forms.*

Instructions for completing this form

Claim Receipts: Attach the original register receipt(s) and prescription information included with your prescription bag to this completed claim form.

Register receipts or prescription information must include the following information. Please list the amount paid on the line provided.

- Prescription fill/purchase date
- Pharmacy name and address
- Prescriber name and prescriber NPI
- National Drug Code (NDC)
- Drug name, strength, and dosage form
- Prescription number (Rx number)
- Dispense as Written (DAW)
- Amount Paid $ _____

Mail completed form(s) with register receipts and other supporting documents to: Capital Rx, Inc. Attn: Claims Dept. 9450 SW Gemini Dr., #87234, Beaverton, OR 97008. You can also email all documents for processing to dmr@cap-rx.com.

1. Always present your member ID card at the participating retail pharmacy.
2. Use this form when you have paid full price for a prescription drug at a retail pharmacy.
3. You must complete a separate claim form for each pharmacy and patient.
4. You must submit within one (1) year of the date of service or as required by your plan.
   For Medicare Only: Claims must be submitted within 36 months from the date of service
5. For your request to be processed, all receipts must contain the information listed within this form. Your pharmacist can provide the necessary information if your claim or bill is not itemized. Please note that a cash register receipt is not sufficient.
   For Medicare Only: Completion of the Prescription Drug Claim form is recommended but not required. You may submit equivalent written documentation, but it must provide all the requested information on this form. Please note that missing, incomplete, or hard-to-read documentation can delay the successful processing of your claim.
6. Incomplete forms may be returned or delay the process.
7. Please make copies of all documents for your records.
8. Reimbursement of submitted claims is subject to your prescription benefit program and is not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and will be for the amount your program would have paid on your behalf. The reimbursement amount may be significantly lower than the original amount you paid. Please remember that completing this form is not a reimbursement guarantee.

Insurance Fraud Warning: *It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.*