TrueScripts™ Amazing Care

Prescription Drug Claim Reimbursement Form

Each Pharmacy Receipt Must Show:

- Participant Name
- Prescription Number
- Pharmacy Name and Address or NABP Number
- Name/Strength and NDC Number
- Metric Quantity/Days Supply
- Dispense as written (DAW), if applicable
- Doctor's Name or DEA Number
- Purchase Date
- Total Charge

The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

PLEASE COMPLETE SECTIONS 1 THROUGH 4. INCLUDE RECEIPTS BEFORE MAILING

Please use a separate claim form for each covered member of the family

1. CARDHOLDER INFORMATION

Primary Participant ID# **(required)**

Plan/Group ID #

Plan Sponsor/Employer

Last Name

First Name M.I.

Mailing Address - Street Apt.

City State Zip Code

Daytime Phone Number - - ext.

2. PARTICIPANT INFORMATION

Participant's Last Name

Participant's First Name M.I.

Participant's Birthdate

Month Day Year

Gender: M F

Number of Receipts:_____

Participant's Relationship to Card Holder:

___ Self ___ Spouse ___ Daughter ___ Son

___ Widowed ___ Full Time Student

___ Sponsored Dependent/Other

Was this prescription obtained while traveling/residing outside the United States? ___ Yes ___ No

Coordination of Benefits

Is the Med. covered under any other group insurance?

If yes, is other coverage: ___Primary ___Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company _____

ID # _____

3. REASON FOR CLAIM OR SPECIAL NOTES

4. IMPORTANT! A SIGNATURE IS REQUIRED IN BOTH A AND B

FRAUD PREVENTION REGULATION: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A. _____ _____

Signature of Plan Participant **Date**

RELEASE OF INFORMATION: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury. I have indicated in the COB box above if there is primary prescription drug coverage under another medical plan. I authorize release of all information pertaining to this claim to TrueScripts, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

B. _____ _____

Signature of Plan Participant **Date**

PLEASE MAIL THIS FORM AND ALL **ORIGINAL PRESCRIPTION RECEIPTS** TO:

TrueScripts Member Care Services: 1-844-257-1955

TrueScripts Management Services
Attn: Claims
513 E South Street
Washington, IN 47501