Prescription Drug Claim Form

Capital Rx

Important: Please read instructions prior to completing this form.

Policyholder:

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims purchased without using your drug card.
2. For a list of participating pharmacies in your area, please refer to our website at www.cap-rx.com or call the Customer Service number on the back of your Prescription Drug Card.
3. Please provide all information requested in **Section 1** for both the patient and policyholder.
4. Sign and date the form in the area provided.
5. Have your pharmacist complete **Section 2 on page 2** of the form.
6. Mail completed form along with the original pharmacy and cash register receipts to: **Capital Rx, Inc. Attn: Claims Dept., 228 Park Avenue, South, Suite 87234, New York, NY 10003**.
7. If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
8. Incomplete forms may be returned and/or delay the process.
9. Please make copies of all documents for your own records.
10. Once your claim is successfully processed, you will be reimbursed directly for all covered services up to the allowed amount.
11. Reimbursement is not guaranteed and are subject to your plan's limits, exclusions and provisions.
See Note on bottom of page 2.

SECTION 1

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. Plan or Employer Name ____________________
5. Patient's Name (First, Middle, Last) ____________________
6. Patient's Birth Date ____________________
7. Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent
8. Is the patient eligible for any other Prescription Drug Coverage? ☐ Yes ☐ No

If yes, complete the following:

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

Insured's Name ____________________ Insured's ID Number ____________________

Insured's Birth Date ____________________ Effective Date ____________________

Insurance Company Name ____________________

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 Capital Rx.

Signature ____________________ Date ____________________

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Pharmacist:

1. Please provide all information requested in **Section 2**.
2. Attach the original receipt and prescription information received on your prescription bag to this form.

Important: Please complete additional claim forms if the member has more than two prescriptions!

SECTION 2

Fill out the information below and attach the original receipt and prescription information received on your prescription bag to this form.

1.Rx Number	Date Filled	Check One ☐ New Rx ☐ Refill Rx	Metric Quantity	Days Supply	MD Name	Is Rx No DAW ☐ 0 MD DAW ☐ 1 Patient DAW ☐ 2 RPh DAW ☐ 3 No Generic ☐ 4	Rx Price (including tax)
	Prescription Date	Number of Refills			Prescriber ID No.		Ingredient Cost $
							Gross Cost $
Medication Name, Strength, Dosage Form			Is Drug Compound Rx ☐		NDC Number (if compound, include NDCs for all active ingredients)		U&C Cost $
Compound Ingredient 2			Metric Quantity		NDC Number		
Compound Ingredient 3			Metric Quantity		NDC Number		
Compound Ingredient 4			Metric Quantity		NDC Number		
2. Rx Number	Date Filled	Check One ☐ New Rx ☐ Refill Rx	Metric Quantity	Days Supply	MD Name	Is Rx No DAW ☐ 0 MD DAW ☐ 1 Patient DAW ☐ 2 RPh DAW ☐ 3 No Generic ☐ 4	Rx Price (including tax)
	Prescription Date	Number of Refills		Prescriber ID No			Ingredient Cost $
							Gross Cost $
Medication Name, Strength, Dosage Form			Drug Compound Rx ☐		NDC Number (if compound, include NDCs for all active ingredients)		U&C Cost $
Compound Ingredient 2			Metric Quantity		NDC Number		
Compound Ingredient 3			Metric Quantity		NDC Number		
Compound Ingredient 4			Metric Quantity		NDC Number		

Please complete additional claim forms if the Member has more than two prescriptions.

Pharmacy Name ______________________ Phone No. ______________ Street ______________________

City _________________________________ State __________________ Zip Code __________

Provider NPI __________________________

Important: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to Capital Rx's approval.

Please return completed form along with the original pharmacy and cash register receipts to **Capital Rx, Inc. Attn: Claims Dept., 228 Park Avenue South, Suite 87234, New York, NY 10003.**

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

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