Prescription Drug Claim Form

Direct Member Reimbursement

This claim form can be used to request reimbursement of covered expenses. Please check which reason applies.

- ☐ I did not have my ID card at the time of purchase.
- ☐ I was charged for medication received during an Urgent/Emergent visit.
- ☐ I was administered a Medicare Part D covered vaccine in my doctor's office.
- ☐ Primary coverage is with another insurance carrier. (Coordination of Benefits)

Additional Explanation: _____

_____

Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on your member ID card.
2. Submit claims within the filing period specified by your Benefit plan. For questions about your filing period please review your Member handbook or call the Customer Care number on your member ID card.
3. Please submit a separate form for each patient for which you purchased medications.
4. Reimbursement will be made directly to the CARDHOLDER unless otherwise noted.

First Name	Last Name	MI
Telephone Number	Date of Birth	Gender (Choose One) ☐ Male ☐ Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information

1. Complete ALL information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

Name		
Street Address		
City	State	ZIP Code
Pharmacy National Provider Number (NPI)		Telephone Number

Part 3: Receipt Information

1. Include original pharmacy receipt(s) or pharmacy printout(s); Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape original pharmacy receipt(s) to bottom of this page. Please DO NOT staple.
2. Receipt(s) must contain the information outlined under Part 3. If your receipt(s) are missing any of this information, have your pharmacist fill in the missing information under Part 3.
3. Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.
4. An incomplete form may be denied, delayed or returned.
5. Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

Rx Written Date	Date Rx Filled	Medication Name
Rx Number	Diagnosis Code and Description	
National Drug Code	Quantity	Day Supply
Prescribing Physician First/Last Name		Prescribing Physician NPI
Original Cost of Rx	Amount Primary Insurance Paid on Rx	Member Paid Amount

Mail this form, along with receipt(s) to:
FirstCare Health Plans
Pharmacy Department
12940 N. Hwy 183
Austin, TX 78750

-OR-

Fax this form, along with receipt(s) to:
(806) 993-7736