Prescription Claim Reimbursement Form

HEALTH REPUBLIC INSURANCE OF NEW YORK

USscript

For claim reimbursement, complete and mail this form to US Script, 2425 W. Shaw Ave., Fresno, CA 93711. Forms can also be faxed to (559) 244-3793. **Incomplete forms will delay processing.** US Script's customer service desk can be reached at (800) 413-7721.

****To be completed by insured. Please PRINT clearly.**

I. MEMBER INFORMATION		II. PRESCRIPTION PLAN INFORMATION
Member Name:		Insured's Member ID #:
Address:		Group #:
Birth Date:	Phone:	Employer:

III. PATIENT INFORMATION

Relationship to insured:

☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

Is patient covered by any other medical benefit plan, group policy repayment plan, Medicare, or other government plans?

☐ Yes ☐ No

If Yes, give the name of the person carrying coverage: _____

If Yes, name of the alternate coverage (group name, employer, association, etc):_____

Patient illness or injury (if injury, include a description of the accident, including date and place).

Did condition result from employment?

☐ Yes ☐ No

If Yes, date you last worked prior to treatment for which claim was made:
_____/_____/_____

IV. PRESCRIPTION INFORMATION

This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription. Also, include a copy of your pharmacy receipt with this form.

Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: ____/____/____	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:
Pharmacy Name:		Pharmacy Address:	
RX Number:		Date Filled: ____/____/____	Quantity:
RX Name & Strength:		Days Supply (30, 60, 90):	
NDC #:	DAW:	Price:	Comments:

Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to US Script and my plan sponsor.

Signature: _____ **Date signed:** _____