PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Policyholder Information *(Reference your member ID card)*
Member ID: _____ Group Number: _____
First Name: _____ Middle Initial: _____
Last Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____

Patient Information *(If different than the policyholder)*
First Name: _____ Middle Initial: _____
Last Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Relationship to Policyholder: ☐ Spouse ☐ Child ☐ Other Dependent

Additional Claim Information
Check all applicable boxes and ensure claim specific section below is complete.

- ☐ Standard Prescription *(Complete page 1 and Claims Receipts section on page 2.)*
- ☐ Compound Prescription
- ☐ Medicare Out-of-Network Purchase
- ☐ Medicare Part D Vaccine
- ☐ Medicaid

Pharmacy Information
Pharmacy Name: _____
Street Address: _____ City: _____
State: _____ Zip Code: _____ Pharmacy NPI: _____

Coordination of Benefits
Is this medication for an on-the-job injury? ☐Yes ☐No
Is this medication covered under any other group insurance plan? ☐Yes ☐No
If yes, provide the name of the insurance company and other employer
ID number for other insurances _____
Employer Name for other insurance _____
Phone Number for other insurances _____

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://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00943110*

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 documents for processing to dmr@cap-rx.com

Compound Prescriptions Only

Rx Number:		Prescription Fill Date:		Day Supply:	

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

- List the valid 11-digit NDC number for each ingredient used for the compound prescription.
- For each NDC number, indicate the metric quantity in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Include the total charge paid by the patient. (dollar amount)
- Receipts must be included with the completed claim form.

COVID-19 At-home Test Kits Only

Kit Name: _____ Number of Tests in Kit: _____ Purchase Date: _____

- Include the image of the COVID-19 At-Home Test Kit package with a visible barcode.
- Include register receipts with the date of purchase. Multiple line items on your receipt? Please circle or highlight the COVID-19 At-Home Test Kit line item for ease of processing.

Medicare Only: Out-of-Network Purchase

Please check the reason that best applies to your situation. Were any prescriptions filled because of:
Illness after traveling outside of the service area? ☐Yes ☐No
No network pharmacy within reasonable driving distance? ☐Yes ☐No
Medication not in stock at my network pharmacy? ☐Yes ☐No
Vaccine received at my doctor's office ☐Yes ☐No
Federal emergency/natural disaster ☐Yes ☐No

Medicare Only: Part D Vaccine Claim

Date Filled: _____ Vaccine Name: _____ NPI Number: _____ Rx Number: _____
Total Paid for Vaccine: _____ Total Paid for Administrative Fee: _____
Vaccine NDC Number: _____ Prescribing Physician: _____
Prescribing Physician Address: _____
Is this a 2-part vaccine? *(i.e., Shingrix)*: ☐Yes ☐No If yes, is this shot: ☐First part in a series ☐Second part in a series
'Circle' Administered Location: Physician Office Clinic Pharmacy

Claim Receipts: Attach the original register receipt(s) and prescription information included with your prescription bag to this completed claim form. Please refer to the COVID-19 At-home Test Kit section for receipt requirements.
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 $_____

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 from 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 pan 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.*

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025.

Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but not limited to race, color, national origin, age, disability, or sexual orientation or gender expression. If you need language assistance, services are available at no cost. Call (505) 923-5420, 1-855-592-7737 (TTY: 711).

ATENCIÓN: Si usted prefiere hablar en español, están a su disposición servicios gratuitos de ayuda lingüística. Llame al (505) 923-5420, 1-855-592-7737 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih (505) 923-5420, 1-855-592-7737 (TTY: 711).

For more information, visit **https://www.phs.org/nondiscrimination.**