PRESBYTERIAN
Health Plan, Inc.

P.O. Box 27489, Albuquerque, NM 87125-7489
www.phs.org

Turquoise Care Prescription Drug Reimbursement Claim Form

If you would like help submitting this claim form, please contact the Presbyterian Pharmacy Services team by email at **askpharmacy@phs.org**. You may also call the Presbyterian Customer Service Center and follow the prompts for pharmacy, contact us at:

Phone: (505) 923-5200 or
1-888-977-2333
(TTY 711)

Navajo/Diné:
(505) 923–5157 or
1-888-806-8793
(TTY 711)

Hours: 8 a.m. to 6 p.m.
Monday - Friday
(except holidays)

Email: **info@phs.org**

Please submit claim forms by mail or email:

Address: Capital Rx, Inc.
Attn: Claims Dept.
9450 SW Gemini Dr., #87234
Beaverton, OR 97008

Email: dmr@cap-rx.com

CLAIM FILING INSTRUCTIONS

Prescription/Pharmacy claims must include a cash register receipt and prescription pamphlet or patient profile from the dispensing pharmacy which contains the following:

- ☐ Patient's name
- ☐ Prescription number
- ☐ Drug name
- ☐ Purchase date
- ☐ Quantity and amount taken daily
- ☐ Name of Prescriber
- ☐ Amount of each prescription, including tax
- ☐ Pharmacy's name and address

SECTION 1: MEMBER/PATIENT INFORMATION

First Name, MI, Last Name:	**Gender:** ☐ M ☐ F	**DOB:** (mm/dd/yy)	**Member ID Number:**	
Address:	**City:**		**State:**	**ZIP Code:**
Home Phone:	**Work/Message Phone:**		**Email Address:**	

Such services are funded in part with the State of New Mexico.

Presbyterian exists to ensure all of the patients, members and communities we serve can achieve their best health.

www.phs.org/Medicaid

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SECTION 2: TREATING PROVIDER/PRACTITIONER INFORMATION		
Provider/Practitioner Name:	**City:**	**State:**
Location where services were received:		**Phone Number:**

SECTION 3: CLAIM INFORMATION

1. **Was the condition/treatment related to one of the following (please check one):**
☐Illness diagnosed prior to enrolling with Presbyterian. ☐Auto accident ☐Patient's employment ☐Other accident ☐Other, please describe:
2. **Does patient have other health insurance coverage? Yes☐ No☐**
If "yes," Policy Holder Policy Number Insurance Company

SECTION 4: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process this claim. All legal-age members or the parent/legal guardian of a minor child member must sign and date this claim form. By signing this form, I attest that the products submitted for reimbursement were used for me or my family.

Name of Member *(please print)* (or Legal Guardian)	**Signature of Member** (*required*) (or Legal Guardian)	**Today's Date**
_____	_____	_____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FORM FOR PAYMENT OF A LOSS OF BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. PRESBYTERIAN INSURANCE COMPANY, INC. MAY TERMINATE A MEMBER FOR ANY TYPE OF FRAUDULENT ACTIVITY.

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, kojį' hódíílnih (505) 923-5420, 1-855-592-7737 (TTY: 711).

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

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