

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: (mm/dd/yy)	Member ID Number:	
Address:	City:	State:	ZIP Code:	
Home Phone:	Work/Message Phone:	Email Address:		

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
 Other accident
 Patient's employment
 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 nínizin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódílnih (505) 923-5420, 1-855-592-7737 (TTY: 711).

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