Prescription drug reimbursement claim form



Member information	Prescription for:
ID number from membership card:	Name
LGB	□ Self □ Spouse □ Dependent/Child
□ Male □ Female	I certify that: • The information on this form is correct
Date of birth:	The member named above is eligible for pharmacy benefits
	 The member named above received the medicine(s) listed These benefits have not been assigned; any further assignment is void
Cardholder name (First, Last)	Member or legal representative signature
	Is this medicine for an on-the-job injury?
Street address	Do you have other insurance for this prescription medicine?
City State ZIP	If yes, what is the other insurance company's name?

Drug name	Date filled	Rx#

Instructions

- 1. All information provided on or attached to this claim form must be for the same person.
- 2. Attach original itemized cash register receipts and valid prescription receipt (usually attached to bag). Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: Your claim will be sent back if required information is missing.

Required information Member name

- Pharmacy name and address
- · Total amount paid
- ID number • Drug name and NDC number Group number
- · Date of birth

3. Send this completed form with itemized receipts to:

- Prime Therapeutics LLC P.O. Box 25188 Lehigh Valley, PA 18002-5188
- 4. Keep a copy of this form and your receipt(s) for your records.

Questions?

- You can call the number on the back of your member ID card.
- Your pharmacist may call 844.765.2897.

Fraud prevention regulation: Any person who knowingly and with intent to defraud any health plan or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent health plan act, which is a crime and subjects such person to criminal and civil penalties.

Prime Therapeutics LLC is an independent company that provides pharmacy solutions for LGHIB members.

- Quantity
- · Date filled
- Rx number