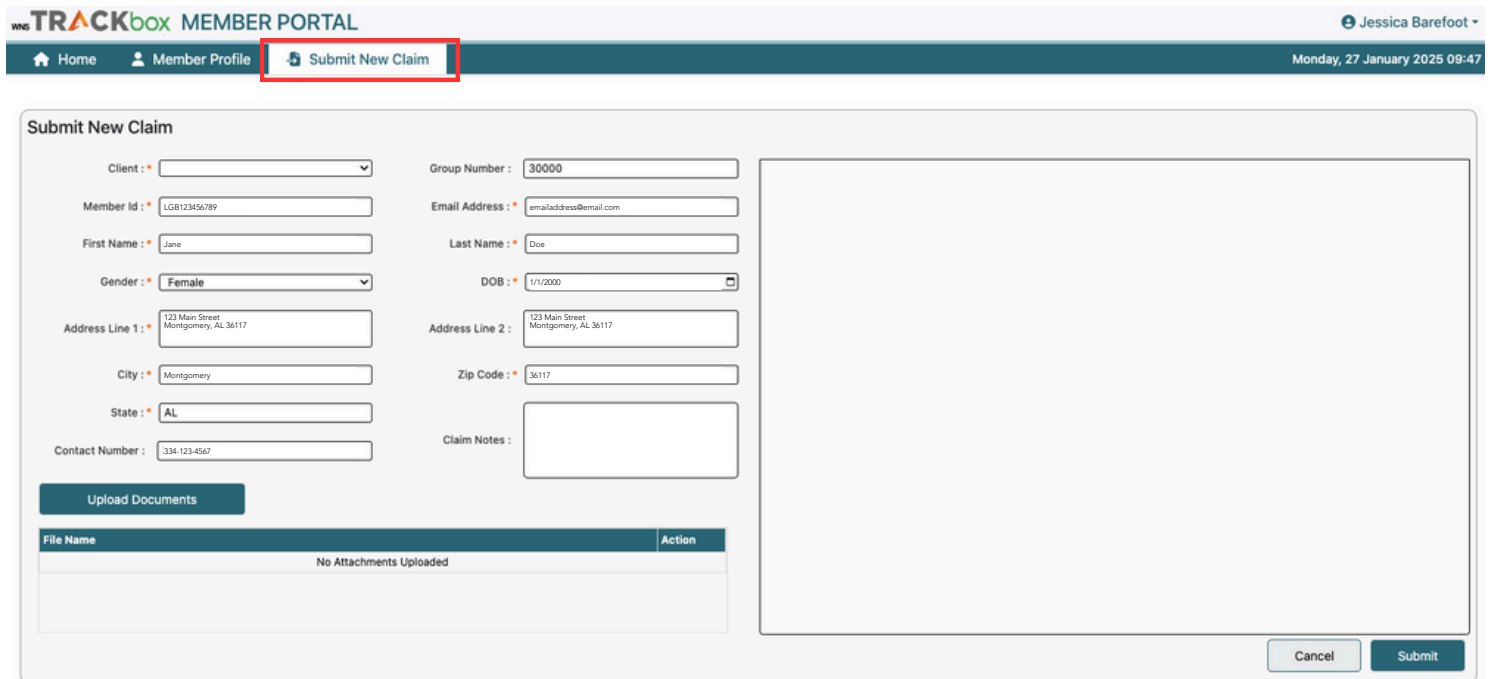


Prime Therapeutics Online DMR Submission Instructions

Upon login, you will be automatically directed to the "Submit New Claim" page.

The information provided upon creating an account will be preloaded in the boxes and saved for future use.



TRACKbox MEMBER PORTAL Jessica Barefoot

Home Member Profile **Submit New Claim** Monday, 27 January 2025 09:47

Submit New Claim

Client :

Member Id :

First Name :

Gender :

Address Line 1 :

City :

State :

Contact Number :

Group Number :

Email Address :

Last Name :

DOB :

Address Line 2 :

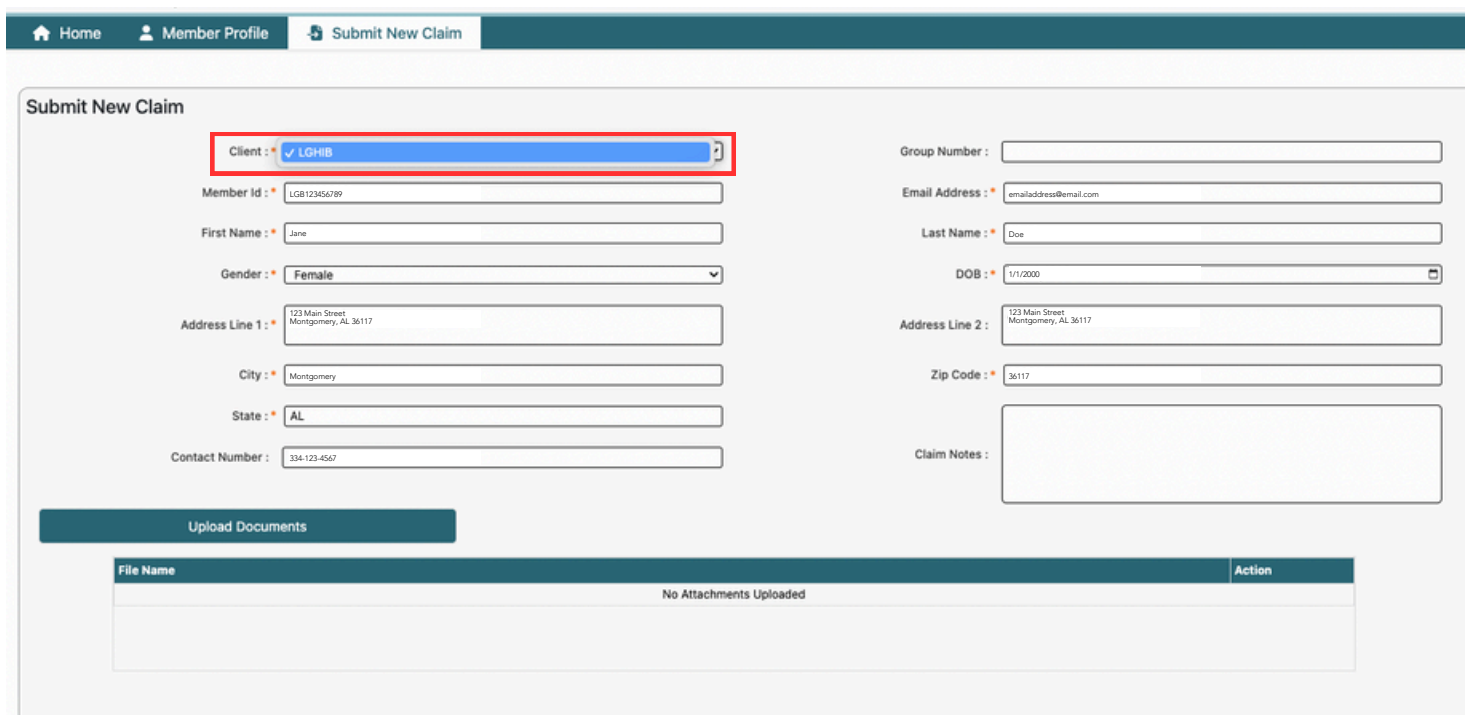
Zip Code :

Claim Notes :

Upload Documents

File Name	Action
No Attachments Uploaded	

In the "Client" dropdown menu, select "LGHIB".



Home Member Profile **Submit New Claim**

Submit New Claim

Client :

Member Id :

First Name :

Gender :

Address Line 1 :

City :

State :

Contact Number :

Group Number :

Email Address :

Last Name :

DOB :

Address Line 2 :

Zip Code :

Claim Notes :

Upload Documents

File Name	Action
No Attachments Uploaded	

A preview of the claim form will appear on the right side of the screen.

the TRACKbox MEMBER PORTAL Jessica Barefoot

Home Member Profile Submit New Claim Monday, 27 January 2025 10:12

Submit New Claim

Client: Group Number:

Member Id: Email Address:

First Name: Last Name:

Gender: DOB:

Address Line 1: Address Line 2:

City: Zip Code:

State: Claim Notes:

Contact Number:

[Upload Documents](#)

File Name	Action
No Attachments Uploaded	

Prescription drug reimbursement claim form

Member information

ID number from membership card: _____

LGB: _____

Male Female

Date of birth: / /

Cardholder name (First, Last) _____

Street address _____

City _____ State _____ ZIP _____

Prescription for:

Name _____

Self Spouse Dependent/Child

I certify that:

- The information on this form is correct
- 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

Member or legal representative signature

Is this medicine for an on-the-job injury? Yes No

Do you have other insurance for this prescription? Yes No

If yes, what is the other insurance company's name? _____

Drug name	Date filled	Rx#

Upload your documents (pharmacy receipt and cash register receipt).

Upload Documents

File Name	Action
Test Receipt Upload.pdf (0.01 MB)	<input type="checkbox"/>
Test Receipt Upload 2.pdf (0.01 MB)	<input type="checkbox"/>

0.02 MB of total 25 MB file size utilized.

Pharmacy Receipt Example:

Community Pharmacy

Smith, John | Counsel - Prescription Schedule
DOB 1/1/1985

Prescription Information

MEDICATION NAME HERE

Take 1 tablet twice a day

Important Information

- Take with or immediately after food.
- Take or use this exactly as directed. Do not skip doses or discontinue.
- May cause dizziness.
- May cause drowsiness. Alcohol intensifies effect. Use care using machines.

Receipt & Refill Information

<p>Community Pharmacy Telephone 334-123-4567 RX 1234567</p> <p>INSURANCE INFORMATION: Prime Therapeutics PAID: \$300.00</p> <p>Retail Price: \$300.00</p>	<p>MEDICATION NAME 50 MG TAB</p> <p>NDC: 12345-6789-10 QTY: 60</p> <p>MFR: REFILLS: 1 PRESCRIBER: DR. SMITH DAYS SUPPLY: 30 DATE FILLED: 1/1/2025</p> <p>AMOUNT DUE: \$100.00</p>
---	--

Cash Register Receipt Example:

Community Pharmacy

123 MAIN STREET
MONTGOMERY, AL 36117
334-123-4567

1 MEDICATION NAME	\$100.00
SUBTOTAL	\$100.00
TAX	\$10.00
TOTAL	\$110.00

VISA XXXXXXXXXXXX6789

Thanks for shopping with us!

Click "Submit"

Cancel

Submit

Upon submission, users will receive a confirmation email.

Notification

Hello Jane Doe,

This is to confirm you that your claim has been successfully submitted on 01/23/2025 14:51.

Reference No.	3
Member ID	123456789
Name	Jane Doe

Thank You
TRACKbox Team

****This is a system generated email. Please do not reply****

Prime Member Portal URL: <https://primememberportal.wns.com>