

Prescription Drug Claim Form

Instructions for completing Prescription Drug Claim Form:

Please complete all sections of the claim form below.

- Only one patient can be submitted per claim form.
- Copies of pharmacy receipts and register receipts must be included with submitted claim form.
- The pharmacy receipts must show the following prescription information for each expense:
 - Pharmacy Name and Address
 - Patient Name
 - Prescription Number
 - Fill Date
 - Drug Name, Strength and NDC
 - Quantity and Days-Supply
 - Drug Cost
 - Amount Paid Out-of-Pocket
- Please mail or fax the completed form and accompanying receipts to:
 - Magellan Health Services
 - Attention: Claims Department
 - 11013 W. Broad Street, Suite 500
 - Glen Allen, VA 23060

 - Fax: 1-888-656-3607**

Please Note: This claim will not be processed until this form and accompanying receipts are submitted.

1. Policyholder or Insured Name (First, Middle, Last) _____
Address _____
City _____ State _____ Zip Code _____

2. Policyholder or insured ID No. (as shown on ID Card) _____

3. Why was the insurance or drug card not used for this purchase? _____

4. Patient's Name (First, Middle, Last) _____

5. Patient's Birth Date _____ 6. Patient's Sex Male Female

7. Patient's Relationship to Policyholder:
 Self Spouse Dependent Other

8. Is the patient eligible for any other Prescription Drug Coverage? No Yes If yes, complete the following:
Does the coverage include: Major Medical Drug Other Medical

Insured's Name _____ Insured's ID Number _____
Insured's Birth Date _____ Effective Date _____
Insurance Company Name _____
Address (Street, City, State, Zip Code) _____

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 Magellan Rx Management, its agents or representatives.

Signature _____ Date _____