Pharmacy BenefitDirect
A PDMI COMPANY

P.O. Box 5300
Poland, Ohio 44514
1.800.800.7364, ext. 5402

Prescription Drug Claim Form

CLAIM MUST BE FILED WITHIN ONE (1) YEAR OF PURCHASE DATE.

PART 1

***Indicates required information**

Primary member/subscriber ID number*	Group number	
Group/employer name	Primary subscriber name*	Subscriber date of birth (mm/dd/yyyy)* / /
Patient name (first, middle, last)*	Male ☐ Female ☐ / Date of birth (mm/dd/yyyy)* / /	Relationship to primary subscriber Self ☐ Spouse ☐ Dependent ☐ Domestic Partner ☐
Address (Street, City, State, ZIP Code)		
I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.		
Member signature*	Telephone number ( )	Date / /

Indicate reasons for filing a claim(s) (select one)*

- ☐ Coordination of benefits—claims must be submitted with pharmacy receipts(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing insurance payment)
- ☐ Medicare is primary prescription coverage
- ☐ Discount card was used
- ☐ Health plan, insurance information or insurance card was not available at the time of purchase
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency—please explain _____
- ☐ Workers' compensation
- ☐ Prescription purchased outside the U.S.
- ☐ Other _____

Submission of claims does not guarantee reimbursement.

PART 2

Rx number	Date filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*
Medication name and strength*	Physician name and NPI number Name _____ NPI _____		Rx price* $	Vaccine admin fee $	Copay* $

Is this a compound? ☐ Yes ☐ No

PART 3

Affix pharmacy label here or enter the required information

Pharmacy name*			Pharmacy telephone number	
Street address			NPI*	
City	State	ZIP code	Pharmacy representative signature*	Date* / /

Please mail this form with your RECEIPT to Pharmacy BenefitDirect, P.O. Box 5300, Poland, Ohio 44514.

Prescription Drug Claim Form

Rx number	Date filled*	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number	Rx price*	Vaccine admin fee	Copay*
	Name ______________________________ NPI ________________________________	$	$	$

Is this a compound? ☐ Yes ☐ No

Rx number	Date filled*	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number	Rx price*	Vaccine admin fee	Copay*
	Name ______________________________ NPI ________________________________	$	$	$

Is this a compound? ☐ Yes ☐ No

Rx number	Date filled*	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number	Rx price*	Vaccine admin fee	Copay*
	Name ______________________________ NPI ________________________________	$	$	$

Is this a compound? ☐ Yes ☐ No

Rx number	Date filled*	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number	Rx price*	Vaccine admin fee	Copay*
	Name ______________________________ NPI ________________________________	$	$	$

Is this a compound? ☐ Yes ☐ No

Rx number	Date filled*	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number	Rx price*	Vaccine admin fee	Copay*
	Name ______________________________ NPI ________________________________	$	$	$

Is this a compound? ☐ Yes ☐ No

Rx number	Date filled*	New ☐ Refill ☐ (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number	Rx price*	Vaccine admin fee	Copay*
	Name ______________________________ NPI ________________________________	$	$	$

Is this a compound? ☐ Yes ☐ No