RxAdvance

PRESCRIPTION DRUG CLAIM FORM

Please remember to keep a copy of the completed claim form and receipt(s) for your records.

Send the completed form (all pages) and all receipt(s) to:
ATTN: Consumer Services, RxAdvance, PO Box 504, Southborough, MA 01772
or Fax: 866-634-7622

Note: RxAdvance cannot process incomplete forms. This form must be filled out completely. Incomplete forms will be returned. Manual submission of claims does not guarantee reimbursement. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit as per plan policy and procedures. If you or your pharmacist need assistance or have any questions, please call the number on the back of your Member ID Card. Claims are processed within 14 days from date of receipt. Reimbursements checks are sent separately from the explanation of payment.

Pharmacy Claim Form Instructions

PART 1: Member Information

Provide the required member information by completing Part 1.

1. Complete all information under Part 1. Member information is located on your Member ID Card.
2. Please submit claims within the filing period specified by your health plan. For questions about your filing period, please call the Member Services phone number listed on the back of your Member ID Card.
3. Please submit a separate claim form for each pharmacy from which you have purchased drugs.

PART 2: Prescription Information

Provide the prescription information by either completing Part 2 or by submitting official pharmacy documents containing the required information with this form. Please ask your pharmacist if you need assistance completing this section. If your prescription is for a compound medication, please ask your pharmacist for a printout of the Compound Drug Information and submit it with the completed form.

Required Prescription Information

- Medication Name & Strength
- National Drug Code (11-digit NDC)
- Prescriber Name
- Date Filled
- Quantity
- Days' Supply
- Paid Amount

PART 3: Proof of Payment

Please attach Proof of Payment.

Acceptable Documents Showing Proof of Payment:

- Cashier's receipt you received when paying for your prescription *OR*
- Financial statement you receive from the pharmacy ***with a pharmacist's signature***

IMPORTANT NOTE: We are unable to process requests without acceptable Proof of Payment.

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*** Required Information**

PART 1: Member Information

Provide the required information. Member information is located on your Member ID Card.

Member Name*	Member ID #*	Member Date of Birth* (MM/DD/YYYY)

Member Address		
City	State	Zip Code

Member Signature*	Date (MM/DD/YYYY)*

PART 2: Prescription Information

Provide the required information by either completing the section below or by submitting official pharmacy documents containing the required information with this form. Please ask your pharmacist if you need assistance completing this section.

Required Prescription Information

- Medication Name & Strength
- National Drug Code (11-digit NDC)
- Prescriber Name
- Date Filled
- Quantity
- Days' Supply
- Paid Amount

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PRESCRIPTION DRUG CLAIM FORM

*** Required Information**

Rx#	Medication Name & Strength*			National Drug Code* (11-digit NDC)		☐ New ☐ Refill (Check One)
Prescriber Name*	Date Filled* (MM/DD/YYYY)	Qty*		Days' Supply*	Paid Amt*	

Rx#	Medication Name & Strength*			National Drug Code* (11-digit NDC)		☐ New ☐ Refill (Check One)
Prescriber Name*	Date Filled* (MM/DD/YYYY)	Qty*		Days' Supply*	Paid Amt*	

Rx#	Medication Name & Strength*			National Drug Code* (11-digit NDC)		☐ New ☐ Refill (Check One)
Prescriber Name*	Date Filled* (MM/DD/YYYY)	Qty*		Days' Supply*	Paid Amt*	

Compound Drug Information

Is this prescription claim for a compound medication? ☐ Yes ☐ No

If yes, *please have your pharmacist provide a printout of the Compound Drug Information and submit it with thecompleted form. Make sure your pharmacist lists* ***ALL the VALID NDC*** *numbers, costs, and quantities for each ingredient on the back of this form and attach receipts. Claims will be returned if incomplete.*

Rx#	Medication Name & Strength*	Date Filled* (MM/DD/YYYY)	Days' Supply*

National Drug Code* (11-digit NDC)											Qty*	Ingredient Cost*

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PRESCRIPTION DRUG CLAIM FORM

											Total	
Signature of Pharmacist*												

PART 3: Proof of Payment

Please submit Proof of Payment with this form.

Acceptable Documents Showing Proof of Payment:

- Cashier's receipt you received when paying for your prescription *OR*
- Printed financial statement you receive from the pharmacy ***with a pharmacist's signature***

IMPORTANT NOTE: We are unable to process requests without acceptable Proof of Payment.

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Important Claim Notices
Caution: Any person who knowingly and with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties.
Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana, North Carolina, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
Connecticut: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim, insurance application or other benefit containing any false, incomplete or misleading information is guilty of a felony. The offense includes conspiracy.
Delaware, Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Indiana: A person who knowingly and with intent to defraud an insurer file a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kansas: WARNING: Acceptance of employment with a different employer that requires the performance of activities you have stated you cannot perform because of the injury for which you are receiving temporary disability benefits could constitute fraud and could result in loss of future benefits and restitution of prior workers compensation awards and benefits paid.
Maine, Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, applies or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania: Any person who knowingly and with intent to defraud any insurer or self-insured 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.