Prescription Drug Claim Form

QualChoice® HEALTH INSURANCE Magellan Rx MANAGEMENT

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** _____

magellanrx.com