PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

A. SUBSCRIBER INFORMATION

FOR OFFICE USE ONLY

Claim # ______________________

ID# **Contract #**

Subscriber's Name
Last First MI

Street Address

City State Zip

SUBSCRIBER'S SIGNATURE:

B. PATIENT INFORMATION

Patient's Name
Last First MI

Date of Birth month day year Male Female **Patient's ID #**

Patient's relationship to insured: Self Spouse Dependent

I certify that all Subscriber and Patient Information is correct and the medication has been dispensed. I authorize release of any information relating to this claim to HIP and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.

PATIENT'S SIGNATURE:

C. PHARMACY INFORMATION

NABP# Tel # area code

Pharmacy Name

Pharmacy Address

City State Zip

I certify that the prescription(s) listed below were lawfully dispensed for the above-named patient, information provided is correct and all supporting document is available for audit.

PHARMACIST'S SIGNATURE:

D1. PRESCRIPTION INFORMATION

Date Dispensed mo dy yr **Rx#:** **New or Refill** (circle one) Name of Medication:

NDC# Quantity Dispensed: Days Supply: Strength:

Prescriber's Name: **Prescriber's State License #**

Presription Cost $.

D2. PRESCRIPTION INFORMATION

Date Dispensed mo dy yr **Rx#:** **New or Refill** (circle one) Name of Medication:

NDC# Quantity Dispensed: Days Supply: Strength:

Prescriber's Name: **Prescriber's State License #**

Presription Cost $.

D3. PRESCRIPTION INFORMATION

Date Dispensed mo dy yr **Rx#:** **New or Refill** (circle one) Name of Medication:

NDC# Quantity Dispensed: Days Supply: Strength:

Prescriber's Name: **Prescriber's State License #**

Presription Cost $.

D4. PRESCRIPTION INFORMATION

Date Dispensed mo dy yr **Rx#:** **New or Refill** (circle one) Name of Medication:

NDC# Quantity Dispensed: Days Supply: Strength:

Prescriber's Name: **Prescriber's State License #**

Presription Cost $.

IMPORTANT: SEE REVERSE FOR INSTRUCTIONS