



PHARMACY SERVICES  
PRESCRIPTION DRUG CLAIM FORM

**A. SUBSCRIBER INFORMATION**

ID # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

(Last)

(First)

(MI)

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SUBSCRIBER'S SIGNATURE \_\_\_\_\_

**FOR OFFICE USE ONLY**

Claim # \_\_\_\_\_

**B. PATIENT INFORMATION**

Patient's Name \_\_\_\_\_

(Last)

(First)

(MI)

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Male \_\_\_ Female \_\_\_ Patient's ID # \_\_\_\_\_

Patient's relationship to insured/subscriber: 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 EmblemHealth and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.

PATIENT'S SIGNATURE: \_\_\_\_\_

**C. PHARMACY INFORMATION**

NABP # \_\_\_\_\_ Telephone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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 \_\_\_ / \_\_\_ / \_\_\_ Rx # \_\_\_\_\_ **New or Refill** Name of Medication \_\_\_\_\_  
(Circle One)

NDC # \_\_\_\_\_ Qty Dispensed \_\_\_\_\_ Days Supply \_\_\_\_\_ Strength \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Prescriber's State License # \_\_\_\_\_

**Prescription Cost** \$ \_\_, \_\_. \_\_. \_\_

**D2. PRESCRIPTION INFORMATION**

Date Dispensed \_\_\_ / \_\_\_ / \_\_\_ Rx # \_\_\_\_\_ **New or Refill** Name of Medication \_\_\_\_\_  
(Circle One)

NDC # \_\_\_\_\_ Qty Dispensed \_\_\_\_\_ Days Supply \_\_\_\_\_ Strength \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Prescriber's State License # \_\_\_\_\_

**Prescription Cost** \$ \_\_, \_\_. \_\_. \_\_

**IMPORTANT: SEE REVERSE FOR INSTRUCTIONS**

**INSTRUCTIONS**  
**PLEASE PRINT ALL SECTIONS**

1. This form is to be used to claim prescription drug benefits provided to eligible EmblemHealth subscribers.
2. EmblemHealth subscribers, please complete sections A and B. We need **all** the information requested to process your claims.
3. Copy subscriber's/patient information from your EmblemHealth Identification Card.
4. Have your pharmacist complete sections C, D1 and D2. **Receipts must be attached.**
5. Use a separate form for each patient. In addition, use a separate form for each pharmacy serving the patient.
6. Send the form to: **EmblemHealth Pharmacy Services, 55 Water Street, New York, NY 10041-8190.**

**Any person who knowingly and with intent to defraud any insurance company 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**