Harvard Pilgrim HealthCare

Prescription Claim Form

Health Plan ______________________________ **Subscriber ID Number: HP**_ _ _ _ _ _ _ _-_-_ _

Subscriber Name ______________________ ______________________ __________________________

(Please print) First Middle Last

______________________________ __________________________ ________ __________

Address City State ZIP Code

Daytime Phone (_____) __________________ Evening Phone (____) ______________________

Prescriptions Were Dispensed To:

Patient Name ______________________ ________________________ ____________________________

First Middle Last

Patient Birth Date: _____________________ Male ___ Female ___

Is this medication for an on-the-job injury? Yes __ No __

Is this medication covered under any other group insurance plan? Yes __ No __

If yes, please name the insurance company and other employer. ______________________________

Name of Insurance Company

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.

Signature of Patient ____

Please attach the duplicate pharmacy generated receipt. If it is unavailable, the pharmacy or dispensing facility must complete the following information. The shaded areas are optional; however, please complete these areas if the information is available.

Rx Number 1)	Date Filled	Check One New___ Refill___	Qty	Directions	Days Supply	Rx Price w/Tax
Medication Name, Form, & Strength		**DAW**		**M.D. DEA#**	**NDC Number (11 digits)**	
Rx Number 2)	**Date Filled**	**Check One New__ Refill__**	**Qty**	**Directions**	**Days Supply**	**Rx Price w/Tax**
Medication Name, Form, & Strength		**DAW**		**M.D. DEA#**	**NDC Number (11 digits)**	

Note: If the prescription was filled in a foreign country, the currency must be converted into US dollars. The diagnosis and a description of the drug are required for processing.

Pharmacy Name _____________________ Pharmacy NABP (Required) __________________________

Address _________________________________ Pharmacy Phone ______________________________

City ________ State ______ ZIP ______Pharmacist's Signature __________________________________

*Pharmacist's signature required when bottom portion of claim form is completed by pharmacy or dispensing facility only.

10680 Treena Street 5th floor ■ San Diego, CA 92131

For assistance, please contact our DMR dept at (858) 566-2727.