



Prescription Claim Form

National Pharmaceutical Services

- 1. Complete this from
- 2. Include all receipts
- 3. Mail to: NPS
PO Box 407
Boys Town, NE 68010

| THIS FORM TO BE COMPLETED BY EMPLOYEE | | | | |
|---|--|---|---------------------|---|
| EMPLOYEE NAME: | MEMBER ID NUMBER: | NAME OF EMPLOYER: | | |
| | | GROUP #: | | |
| STREET ADDRESS: | EMPLOYEE BIRTH DATE: | HEIGHT: _____ WEIGHT: _____ ANY KNOWN ALLERGIES: _____ | | |
| CITY: | IS PATIENT COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO | THIS CLAIM IS: | | |
| STATE: | | <input type="checkbox"/> PRIMARY INS. <input type="checkbox"/> SECONDARY INS. | | |
| ZIP: | | | | |
| PATIENT NAME: (IF OTHER THAN EMPLOYEE) | MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> | PATIENT RELATIONSHIP TO EMPLOYEE: | PATIENT BIRTH DATE: | PHONE NUMBER: HOME: _____ WORK: _____ |
| I certify that the information on this claim form is correct and authorize release of all information to NPS. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan, ie. workman's comp. I understand that drug(s) listed below is not for treatment of an on-the-job injury or covered by any other insurance plan. | | | | |
| Signature: _____ | | | Date: _____ | |

NATIONAL PHARMACEUTICAL SERVICES HELP DESK 800-546-5677

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a member of National Pharmaceutical Services, will receive the "lesser" of usual and customary "U&C" charge of this provider, or the contracted price of the product. Reimbursement may be lower than the amount submitted by your pharmacy provider. NPS network pharmacies are contracted to provide services for your employer group on a fixed reimbursement schedule and this reimbursement reflects these rates. If this reimbursement has been reduced, please see your pharmacy. They are terrific allies in building cost containment programs for our employer groups.

INSTRUCTIONS

BEFORE SENDING THIS CLAIM FORM TO NPS, PLEASE MAKE SURE THE FOLLOWING INFORMATION IS INCLUDED ON THE PHARMACY RECEIPT(S). **DO NOT PRESENT CANCELLED CHECKS OR CASH RECEIPTS.** THEY DO NOT CONTAIN THE INFORMATION NEEDED TO PROCESS A CLAIM. INCOMPLETE INFORMATION WILL ONLY DELAY PAYMENT.

| | | |
|-----------------------------------|------------------------|--|
| Pharmacy Name and Number | Physician Name | Name of the Person Prescription Is For |
| Pharmacy Address and Phone Number | DAW (Doctor Requested) | Date of Prescription |
| Date of Prescription | Brand or Generic | |

PLEASE INCLUDE THE FOLLOWING INFORMATION ABOUT THE PRESCRIPTION(S):

- NABP Number NDC Number Days Supply Amount Paid Name of Prescription Quantity Directions

The NPS staff is available to assist members and pharmacies having difficulty submitting claims for any reason.
Please talk to your pharmacy about the paperless option before you decide to fill out the manual claim form(s).

Our pharmacy network is able to process your claims within a 14-day window.
 Any reimbursement is contingent upon funding from your third party administrator.

REMINDERS

1. Do your provider's bills indicate what services were rendered and for whom?
2. Have you answered all the questions that are applicable to your claim?

THANK YOU VERY MUCH FOR YOUR ASSISTANCE IN THIS PROCESS!