

Prescription Drug Claim Form

UPREHS Prime Medicare Plan
PO Box 161020
Salt Lake City, UT 84116-1020
 Customer Services: 1-800-547-0421
 Fax Number: 801-595-2037

PATIENT & INSURED (SUBSCRIBER) INFORMATION

Patient Name (first, middle, last) _____
 Date of Birth _____
 Patient Street Address (MM/DD/YYYY) _____
 City, State, Zip _____
 Insured's Name (first, middle, last) _____
 Relationship to Patient Self Spouse Child Other _____
 Insured's UPREHS ID Card # _____ Insured's Medicare # _____
 Condition Related To Accident Emergency I/P Services
 Other Insurance Yes No Other Prescription Coverage Yes No Policy _____
 Policy Holder Name _____ Plan Name _____

Patient's or Authorized Person's Signature

I authorize the release of any medical/prescription information necessary to process the claim and request payment of Medicare benefits either to myself or to the party who accepts assignment below.

Patient Signature _____ Date _____

CLAIMS/PRESCRIPTION INFORMATION

* For Compounded drugs: All compounded prescriptions must be submitted on this prescription claim form and provide all NDC's NOT just the NDC of the major ingredient. List the date of service, drug name(s), NDC, strength, quantity, dosage form, and the cost of each ingredient for ALL drugs in the compound. Failure to list any ingredients or quantities will result in a denial for lack of requested information.

Date of Service	Drug Name	NDC No.	Strength	Quantity	Dosage Form	Charge
Signature of Physician or Supplier:		Accept Assignment:	Total Charge	Amount Paid		Balance Due
Date		Yes () No ()				
DEA #		Physician or Supplier Address				
Tax Identification #						
NPI #						
NABP #						

