



PRESCRIPTION CLAIM FORM

Thank you for choosing us for your prescription coverage. Please use the following guidelines when submitting reimbursement requests for medication.

1. This form should only be used for claims covered under a prescription medication benefit. If needed, please contact the customer service number on the back of your medical identification card for information on obtaining a claim form for your medical benefit.
2. Complete one form per patient.
3. Most contracts require that your reimbursement request be received no later than one year from the date the medication was filled.
4. Complete the information below.
5. Write your identification number on the top of each page.
6. Tape your original receipts in the boxes marked for receipts. Receipts must include pharmacy name and address, full name of patient, date filled, quantity, physician name, name of medication or item, prescription number and charge/copayment. **Cash register receipts do not provide enough information.**
7. Retain copies of receipts for your records.
8. Sign the completed form where indicated at the bottom of this page and mail to:
 Pharmacy Services
 PO Box 12625 M/S S2P
 Salem OR 97309
9. Additional forms may be obtained by calling the customer service number on the back of your card or by visiting **www.regencerox.com**.
10. All correspondence including payments and explanations of benefits will be mailed to the address on file. If you need to update or change your mailing information please contact your benefit administrator.

Identification Number _____

Patient's Name _____ Cardholder's Name _____

Patient's Date of Birth _____ Daytime Phone (_____) _____

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

If yes, give name of insurance company and ID number _____

Important: The following submissions may be returned to you:

- Any claim that does not include all of the required information listed above.
- Claims for secondary coverage that do not include the explanation of benefits and/or the prescription receipts including retail cost of medication and the amount paid as copayment.

Please indicate why the patient paid cash _____

CERTIFICATION STATEMENT:

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to my prescription medication plan and the underwriter. I agree that any benefits payable hereunder for prescription medications are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civic or criminal prosecution.

▶

Signature

Date

ID Number _____

TAPE RECEIPT HERE
In date order

For Internal Use Only
NABP _____
DEA _____
DAS _____

TAPE RECEIPT HERE
In date order

For Internal Use Only
NABP _____
DEA _____
DAS _____

TAPE RECEIPT HERE
In date order

For Internal Use Only
NABP _____
DEA _____
DAS _____

ID Number _____

TAPE RECEIPT HERE
In date order

For Internal Use Only
NABP _____
DEA _____
DAS _____

TAPE RECEIPT HERE
In date order

For Internal Use Only
NABP _____
DEA _____
DAS _____

TAPE RECEIPT HERE
In date order

For Internal Use Only
NABP _____
DEA _____
DAS _____

Please return this form to:

**Pharmacy Services
PO Box 12625 M/S S2P
Salem OR 97309**