Coordination of Benefits/Direct Claim Form

See the back for instructions. Complete all information. An incomplete form may delay your reimbursement.

Member/Subscriber Information (See your prescription drug ID card.)

GROUP NUMBER:	MEMBER ID:	MEMBER NAME (FIRST, LAST):		
ADDRESS:		CITY:	STATE:	ZIP:

Patient Information

PATIENT NAME (FIRST, LAST):	DATE OF BIRTH (MM/DD/YYYY): / /

SEX: ☐ M ☐ F

RELATIONSHIP TO PLAN MEMBER:

☐ Self ☐ Spouse ☐ Eligible Child ☐ Dependent Student
☐ Disabled Dependent ☐ Dependent Parent ☐ Nonspouse Partner ☐ Other

Pharmacy Information

NAME OF PHARMACY:

ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER: ( ) -	IS THIS AN ON-SITE NURSING HOME PHARMACY? ☐ Yes ☐ No		

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Magellan or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

SIGNATURE OF PHARMACIST OR REPRESENTATIVE (REQUIRED) _____ NABP NUMBER REQUIRED _____

Claim Receipts (Tape receipts or itemized bills on the back. See back for details.)

Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the receipt or bill.

☐ **Medication purchased outside of the United States**
Please indicate: **COUNTRY:** _____ **CURRENCY USED:** _____

☐ **Allergy medication**

Coordination of Benefits

Mark the appropriate box for your primary coverage method. See the back for more information.

Another Health Plan Paid and you are enclosing information that outlines how much you paid and how much the other carrier paid

☐ 1 **Retail Pharmacy**
☐ 2 **Mail/Mail-Order Pharmacy**

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Please tape Receipts on back.

Acknowledgement

The submission of this COB form, for you or your dependents, authorizes the release of all information to applicable health care providers and all others involved in filing the prescriptions and processing the claims submitted. I certify that all of the information on this form is correct and the patient has received the medication described herein.

MEMBER'S SIGNATURE: _____

MAGELLAN PHARMACY SOLUTIONS

Claim Receipts	
Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.	
Tape receipt for prescription 1 here. **Receipts must contain the following information:** ▪ Date prescription filled ▪ Name and address of pharmacy ▪ Doctor name or ID number ▪ NDC number (drug number) ▪ Name of drug and strength ▪ Quantity and days' supply ▪ Prescription number (Rx number) ▪ DAW (Dispense As Written) ▪ Amount paid	Tape receipt for prescription 2 here. **Receipts must contain the following information:** ▪ Date prescription filled ▪ Name and address of pharmacy ▪ Doctor name or ID number ▪ NDC number (drug number) ▪ Name of drug and strength ▪ Quantity and days' supply ▪ Prescription number (Rx number) ▪ DAW (Dispense As Written) ▪ Amount paid

Pharmacy Information (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX NUMBER:	**DATE FILLED (MM/DD/YYYY):** / /	**DAYS' SUPPLY:**
Valid 11-digit NDC Number		**Quantity**
	Total Quantity:	
	Total Charge:	

When To Use This Form

- Use this form to submit claims under Coordination of Benefit Rules.
- You must complete a **separate** claim form for **each pharmacy** used and for **each patient**.
- You must submit claims within 1 year of date of purchase or as required by your plan.
  - **Another Health Plan Paid**

You must first submit the claim to the primary insurance carrier, tape the original prescription receipts in the spaces provided above, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

1. Retail Pharmacies: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

2. Mail-order pharmacy: Complete this form and attach either the prescription receipt(s) that shows the co-payment or coinsurance amount paid to the mail-order pharmacy, or the statement of benefits you receive from the mail-order pharmacy.

*** California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

*** Pennsylvania:** 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 subjects such person to criminal and civil penalties.

Instructions

Read carefully before completing this form.

1. Be sure your receipts are complete. In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
2. The plan member should read the acknowledgment carefully, then sign and date this form.
3. Return the completed form and receipt(s) to:
   Magellan Pharmacy Solutions
   Attn: Paper Claims
   Processing Department
   P.O. Box 85042
   Richmond, VA 23261