Instructions to Follow to Complete the Member Claim Form

We at Magellan want to ensure you promptly receive the benefits to which you are entitled. In order for us to do this, we need all the fields on the claim form completed. An incomplete form cannot be processed and, depending on the missing information, some forms may be returned to you delaying your benefits. The following instructions will help you complete your claims for timely processing.

Section A. Insured Member/Employee Information

The insured member/employee is the person whose employer provides pharmacy benefits. Fill in the member/employee's information in this section.

- Insurance Carrier is the name of the Pharmacy Benefit Plan.
- Group Number is shown on your benefits identification card.
- ID Number is shown on your benefits identification card.
- Name is the insured person.
- Address is the insured person's mailing address.
- Telephone Number is the number the insured person can be reached during business hours.

Section B. Patient Information

Complete this section for the person who received the medication for which you are filing for reimbursement. *If filing for multiple patients, please complete a separate claim form for each patient.*

Section C. COB – Coordination of Benefits/OTHER COVERAGE INFORMATION

If the patient has other pharmacy benefits from another insurance plan that covers the medication, you must complete the COB – Coordination of Benefits Form. You can find this form on the member website or contact Magellan's Customer Service for a copy of the form.

Section D. Reason for Claim Submission

Check the reason which describes why you are submitting a claim.

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Section E. Prescription Information

If you are filing for more than one medication, please complete a copy of Section E for each medication.

Your pharmacy receipt is your first resource for the following information. If the information is not listed on your receipt, consult the dispensing pharmacy for this information.

- **Pharmacy Name** is the name of the pharmacy that dispensed the medication.
- **Pharmacy Address** is the dispensing pharmacy's physical address.
- **Pharmacy Phone Number** is the dispensing pharmacy's business phone number.
- **Pharmacy NPI Number** is the dispensing pharmacy's 10-digit identification number.
- **Prescriber Name** is the prescriber who wrote this prescription.
- **Prescriber NPI** Number is the prescriber's 10-digit identification number.
- **Drug Name** is the name of the medication dispensed.
- **NDC Number** is the medication's 11-digit identification number.
- **RX Number** is the prescription number assigned by the dispensing pharmacy.
- **DAW (Dispense as Written) Code** is a code provided by the prescriber.
- **Prescription Origin** is the method the prescriber used for the prescription (written, faxed, phoned in, etc.).
- **Date Written** is the date the prescriber issued the prescription (format: MM/DD/YYYY).
- **Date Filled** is the date the pharmacy filled the prescription(format: MM/DD/YYYY).
- **Fill Number** is either new or the number of times the prescription has been refilled.
- **Quantity Dispensed** is the quantity of medication received.
- **Days' Supply** is how long the quantity dispensed is expected to last.
- **Unit of Measure or Dosage Form** is the physical type and amount of the medication (tablet, capsule, gram, milliliter, each, etc.).
- **Amount Charged** is the amount the pharmacy charged for the dispensed medication.
- **Amount Paid** is the amount you paid for the dispensed medication.

Section F. Release of Information and Certification Statement

Each claim form you are submitting must be signed and dated. *Unsigned claim forms cannot be processed and will be returned to you.*

Please call Magellan's Pharmacy Customer Service number listed on the back of your card if you have any questions about this form.

Mail this form, with Rx receipt(s) and EOB if applicable, to:

Magellan Pharmacy Solutions
Attn: Paper Claims Processing Department
P.O. Box 85042
Richmond, VA 23261

Member Prescription Claim Form

Please print using blue or black ink. All fields must be completed.

Section A. Insured Member (Employee) Information		
INSURANCE CARRIER:	**GROUP NUMBER:**	**ID NUMBER:**
NAME (FIRST, LAST):		**PHONE NUMBER:** ( ) -
ADDRESS:		
CITY:	**STATE:**	**ZIP:**

Section B. Patient Information	
Complete this section for the patient for whom you are submitting claim(s). ***If more than one patient, please use separate claim form*****.**	
PATIENT NAME:	**DATE OF BIRTH (MM/DD/YYYY):** / /
RELATIONSHIP TO EMPLOYEE:	

Section C. COB – Coordination of Benefits/OTHER COVERAGE INFORMATION (COB form available upon request.)

Does the patient have pharmacy benefits from another insurance plan that covers this medication?*

☐ Yes ☐ No

*If Yes, you are required to complete the COB form located on the member website or call Magellan's Customer Service for a copy of this form. Include a copy of the explanation of benefits (EOB) with this claim form and the completed COB form.

Section D. Check the reason for filing this claim(s):

- ☐ I have not received my ID card.
- ☐ Pharmacy not participating in network.
- ☐ Pharmacy cannot process claim electronically.
- ☐ Emergency – Please describe the emergency on a separate sheet.
- ☐ Other – Please describe below or on a separate sheet.

Please complete the following section to describe 'Other' reason

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Section E. Prescription Information (You may ask your pharmacist to complete this section.)			
PHARMACY NAME:			
PHARMACY ADDRESS:			
CITY:	**STATE:**	**ZIP:**	
PHARMACY PHONE NUMBER: ( ) -	**PHARMACY NPI NUMBER:**		
PRESCRIBER NAME:	**PRESCRIBER NPI NUMBER:**		
DRUG NAME:			
NDC NUMBER:	**RX NUMBER:**	**DAW CODE:**	
PRESCRIPTION ORIGIN (WRITTEN, FAXED, PHONED IN, ETC.):	**DATE WRITTEN (MM/DD/YYYY):** / /	**DATE FILLED (MM/DD/YYYY):** / /	
FILL NUMBER (0 FOR NEW, 1+ FOR REFILL):	**QUANTITY DISPENSED:**	**DAYS' SUPPLY:**	
UNIT OF MEASURE OR DOSAGE FORM (EA, ML, GM):	**AMOUNT CHARGED:**	**AMOUNT PAID:**	

Section F. Release of Information and Certification Statement	
The submission of this claim 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	/ / **DATE (MM/DD/YYYY)**

Please call Magellan's Pharmacy Customer Service number listed on the back of your card if you have any questions about this form.

Mail this form, with Rx receipt(s) and EOB and COB forms if applicable, to:

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