



Instructions to Follow to Complete the Member Claim Form

Revised: October 28, 2022

All fields on the claim form must be completed. An incomplete form cannot be processed and will be returned to you.

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. Reason for Claim Submission

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

Section D. 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 E. Prescription Information

If you are filing for more than one medication, please complete a copy of *Section E – Prescription Information* 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). <i>If more than one patient, please use separate claim form.</i>		
PATIENT NAME:		DATE OF BIRTH (MM/DD/YYYY): / /
RELATIONSHIP TO EMPLOYEE:		
SECTION C. CHECK THE REASON FOR FILING THIS CLAIM(S):		
<input type="checkbox"/> I have not received my ID card. <input type="checkbox"/> Pharmacy not participating in network. <input type="checkbox"/> Pharmacy cannot process claim electronically. <input type="checkbox"/> Emergency – Please describe the emergency on a separate sheet. <input type="checkbox"/> Other – Please describe on a separate sheet.		
SECTION D. 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?* <input type="checkbox"/> Yes <input type="checkbox"/> 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.		

