Prescription Advantage Prescription Drug Reimbursement Form RxPCN: **MPSEAM**
for members eligible for Medicare. **Complete both sides of this form.**

Section 1: Member Information			
Last Name	First Name		MI
Mailing Address	City	State	Zip Code
Phone Number ( )	Date of Birth _____/_____/_____	Prescription Advantage ID Number	
Name of Medicare Part D or Creditable Coverage Drug Plan			
Section 2: Pharmacy Information			
Pharmacy Name	Phone Number ( )	NCPDP or NABP Number (on receipt or contact pharmacy)	
Address	City	State	Zip Code
Section 3: Signature			

I certify that all information on this claim form is accurate. I understand that Prescription Advantage use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as a medical provider, is in accordance with federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Member's Signature Date

_____ _____
Authorized Representative's Signature Date

After completing both sides, please mail this form and documentation (EOB or pharmacy print out) to the following address. For questions, call 1-800-243-4636, or 711 for TTY for the deaf and hard of hearing.

Prescription Advantage
Attn: Benefit Coordination
PO Box 15153
Worcester, MA 01615-0153
Fax to: 508-421-5622

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 penalties.

Include only prescriptions that may require reimbursement.

Claim 1 (please print)					
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)	Quantity
Prescriber's Name (Doctor)	Days Supply	Form (capsules, cream, etc)	Total Charge $	Amt Primary Paid $	Amt You Paid $
Claim 2 (please print)					
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)	Quantity
Prescriber's Name (Doctor)	Days Supply	Form (capsules, cream, etc)	Total Charge $	Amt Primary Paid $	Amt You Paid $
Claim 3 (please print)					
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)	Quantity
Prescriber's Name (Doctor)	Days Supply	Form (capsules, cream, etc)	Total Charge $	Amt Primary Paid $	Amt You Paid $
Claim 4 (please print)					
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)	Quantity
Prescriber's Name (Doctor)	Days Supply	Form (capsules, cream, etc)	Total Charge $	Amt Primary Paid $	Amt You Paid $
Claim 5 (please print)					
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)	Quantity
Prescriber's Name (Doctor)	Days Supply	Form (capsules, cream, etc)	Total Charge $	Amt Primary Paid $	Amt You Paid $
Claim 6 (please print)					
Drug Name	NDC # (on receipt or call pharmacy)	Prescription #	Date of Fill	Dosage (25 mg, etc)	Quantity
Prescriber's Name (Doctor)	Days Supply	Form (capsules, cream, etc)	Total Charge $	Amt Primary Paid $	Amt You Paid $