MedImpact
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Prescription Drug Claim Form

PEEHIP

ATTN: CLAIMS DEPT
MedImpact Healthcare Systems, Inc. 10680 Treena Street 5th floor San Diego, CA 92131

In order to process your claim(s), you must provide all information requested below. Submit the completed form with the original pharmacy prescription label/receipt(s)

Primary Member/Cardholder Information

Primary Member/Cardholder ID Number	Primary Member/Cardholder Name (First, Middle, Last)		
Name of Health Plan/Insurance	**Member Phone Number (Day)**	**Member Phone Number (Evening)**	
	( ) -	( ) -	
Address (Street)	**(City)**	**(State)**	**(Zip Code)**

Patient Information (if different than Primary Member's/Cardholder's)

Patient's Name (First, Middle, Last)	Patient's DOB (MM/DD/YYYY)	Relationship to Primary Member/Cardholder		
		Spouse ❑	Dependent ❑	Other ❑
Address (Street)	**(City)**	**(State)**	**(Zip Code)**	

Other Coverage Information

Covered under any other insurance? Coordination of Benefits (COB) ☐	Worker's Compensation? ☐
If COB, please indicate the name of primary insurance here: _____	If Worker's Compensation is selected, please **stop** and submit claim to your employer.

*Submit either **prescription receipts/labels** with the following information – and/or have your **pharmacist** sign and complete the Prescription Details.

Prescription Details

- Pharmacy Name/Address
- Prescription Number & Date Filled
- Physician's Name or DEA #
- Drug Name & Strength or NDC #
- Quantity and Day Supply Dispensed
- Member Paid Expense

1) Rx Number	Date Filled	Check One	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			Vac Admin Fee	DAW (0-8)	Prescribing Physician's Name/DEA #	Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐		COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer	Copay Paid $

2) Rx Number	Date Filled	Check One	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			Vac Admin Fee	DAW (0-8)	Prescribing Physician's Name/DEA #	Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐		COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer	Copay Paid $

3) Rx Number	Date Filled	Check One	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			Vac Admin Fee	DAW (0-8)	Prescribing Physician's Name/DEA #	Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐		COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer	Copay Paid $

Pharmacy Information

Pharmacy Name			Pharmacy Telephone Number	
Street Address			NABP	
City	State	Zip	Pharmacy Signature	Date

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. I also authorize payment to subscriber unless I have indicated a different payee above.

Claimant Signature **X**

COMPOUND PRESCRIPTIONS

The pharmacy or dispensing facility must complete the remaining portion of this form and return it to the member/patient or provide the member/patient with a Universal Claim Form for a Compounded Medication.*

- **Provide an 11 digit NDC number for each of the ingredients in the medication**
- **Indicate the drug ingredients and quantity for each**
- **Indicate the metric quantity dispensed in the number of tablets, grams or milliliters for liquids, creams, intments or injectable drugs**
- **Indicate the amount paid for the prescription by the patient**

COMPOUND PRESCRIPTIONS
*For pharmacy use only

NDC#	Drug Ingredient	Quantity	Charge
		Total Charge:	$

Note: If purchased in a foreign country, the currency must be converted into US dollars.

- The original paid pharmacy prescription label/receipt (including the required drug information) MUST accompany this claim form. Pharmacy receipts will not be returned, you may wish to make copies for your records.