Prescription Drugs Claim Form

Please read carefully before completing this form. Claim forms that do not include the required information may delay or inhibit our ability to process your request for reimbursement. Completion and submission of this form does not guarantee reimbursement. Claims are subject to limitations, exclusions, and other provisions of your benefit plan. Reimbursement claims are researched and processed once all information has been received. Once all information is received, it takes up to 30 days to make a reimbursement determination.

Member Information (to be completed by the member)

1. Complete all information under Part 1. The member/cardholder ID Number is located on your Flipt insurance card.
2. Submit claims within the filing period specified by your plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary cardholder unless you provide us with an Alternate Address in Part 1.**

Receipt

1. Submit prescription receipts / labels that contain the requested information (shown below) and complete part 3 of the form. Tape or scan receipts to a separate page to be submitted with the claim form
2. **If you do not receive a receipt for your prescription(s), pharmacist signature is required. (See Part 2)**
3. For multiple claims, please use the multiple prescription form.
4. Remember to keep a copy of the completed claim form and receipt(s) for your records
5. Send the completed form and receipt(s) to:

Fax: 551-430-5669
Email:Reimbursements@Fliptrx.com

PRESCRIPTION / PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information. Note: Each pharmacy may have a unique label format.

Pharmacy Name #1234 (216)555-1234
123 This Street **Store NPI: 1234567890**
City, State 12345

RX 1234567 **Date Filled: 1/1/2022**

DOE, John
DOB: 01/01/1900
456 Another Street (509)555-5678
City, State 45678

Amoxicillin 500 mg capsules **DAW: 0**
00000-1111-22 **QTY: 21** **Days Supply: 7**

A. Burch, MD
NPI: 4567890123

U&C: 200.00 **COPAY: 10.00**

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay amount paid to the pharmacy*
12. Pharmacy National Provider ID (NPI)

** Denotes required information to process a claim. If this information is not included, it may delay or inhibit our ability to process your request for reimbursement.*

Prescription Drugs Claim Form

PART 1

***Indicates required information**

Cardholder Name*	**Group Name**
Cardholder ID Number*	**Primary Cardholder DOB: (mm/dd/yyyy) ***
Member Name: (First, Middle, Last) *	**Date of Birth: (mm/dd/yyyy) ***
Cardholder Address: (Street, City, State, Zip code) ☐ ☐ ☐	
Alternate Address: (Street, City, State, Zip code)* If no alternate address is specified, correspondence and/or payment will be forwarded to the primary cardholder address on file with your plan insurance.	
Member Telephone Number: Legal Representative (If Applicable):	

☐**Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid**
☐**Discount Card was used**
☐**Flipt insurance information or insurance card not available at the time of purchase**
☐**Pharmacy not participating in network**
☐**Pharmacy unable to process claim electronically**
☐**Emergency – If Emergency, describe emergency below**

Indicate reason for manually filing these claims (select one) *:

Describe Emergency: _____

PART 2

Pharmacist can enter the required information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			**Pharmacist NPI***	
City	State	Zip	**Pharmacist Signature***	**Date***

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PART 3

RX Number	Date Filled*	New Refill	Quantity*	Day Supply*	National Drug Code (11 Digit) *
Medication Name and Strength *			Physician Name & NPI Number*		Amount Paid (Include amount from Copay Assistance amounts, too) *

RX Number	Date Filled*	New Refill	Quantity*	Day Supply*	National Drug Code (11 Digit) *
Medication Name and Strength *			Physician Name & NPI Number*		Amount Paid (Include amount from Copay Assistance amounts, too) *

RX Number	Date Filled*	New Refill	Quantity*	Day Supply*	National Drug Code (11 Digit) *
Medication Name and Strength *			Physician Name & NPI Number*		Amount Paid (Include amount from Copay Assistance amounts, too) *

RX Number	Date Filled*	New Refill	Quantity*	Day Supply*	National Drug Code (11 Digit) *
Medication Name and Strength *			Physician Name & NPI Number*		Amount Paid (Include amount from Copay Assistance amounts, too) *

Multiple Prescription Claim Form

By signing below, I certify that I have read and understood this form, and that the information provided on this form is true and correct to the best of my knowledge.

Member or Authorized Representative Signature*

Date*

***Indicates required information**