



an EmblemHealth company

PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

A. SUBSCRIBER INFORMATION
ID #
Subscriber's Name (Last, First, MI)
Street Address
City State Zip
SUBSCRIBER'S SIGNATURE

FOR OFFICE USE ONLY
Claim #

B. PATIENT INFORMATION
Patient's Name (Last, First, MI)
Date of Birth / / Male Female Patient's ID #
Patient's relationship to insured/subscriber: Self Spouse Dependent
I certify that all Subscriber and Patient Information is correct and the medication has been dispensed. I authorize release of any information relating to this claim to GHI HMO and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.
PATIENT'S SIGNATURE:

C. PHARMACY INFORMATION
NABP # Telephone #
Pharmacy Name
Pharmacy Address City State Zip
I certify that the prescription(s) listed below were lawfully dispensed for the above-named patient, information provided is correct and all supporting document is available for audit.
PHARMACIST'S SIGNATURE

D1. PRESCRIPTION INFORMATION
Date Dispensed / / Rx # New or Refill Name of Medication
(Circle One)
NDC # Qty Dispensed Days Supply Strength
Prescriber's Name Prescriber's State License #
Prescription Cost \$, .

D2. PRESCRIPTION INFORMATION
Date Dispensed / / Rx # New or Refill Name of Medication
(Circle One)
NDC # Qty Dispensed Days Supply Strength
Prescriber's Name Prescriber's State License #
Prescription Cost \$, .

D3. PRESCRIPTION INFORMATION
Date Dispensed / / Rx # New or Refill Name of Medication
(Circle One)
NDC # Qty Dispensed Days Supply Strength
Prescriber's Name: Prescriber's State License #
Prescription Cost \$, .

IMPORTANT: SEE REVERSE FOR INSTRUCTIONS

INSTRUCTIONS
PLEASE PRINT ALL SECTIONS

1. This form is to be used to claim prescription drug benefits provided to eligible GHI HMO subscribers.
2. GHI HMO subscribers, please complete sections A and B. We need **all** the information requested to process your claims.
3. Copy subscriber's/patient information from your GHI HMO Identification Card.
4. Have your pharmacist complete sections C, D1, D2, and D3. **Receipts must be attached.**
5. Use a separate form for each patient. In addition, use a separate form for each pharmacy serving the patient.
6. Send the form to: **GHI HMO, P.O. Box 1520 JAF Station, New York, NY 10116-1520.**