

Prescription Drug Claim Form



Your clean and complete claim will be processed within 14 days of receipt of your request. Please allow additional mail time.

Policyholder Information *(Reference your member ID card.)*

Member ID: _____ Group Number: _____

Plan or Employer Name: _____

First Name: _____ Middle Initial: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Patient Information: *(If different than the policyholder)*

First Name: _____ Middle Initial: _____

Last Name: _____ Patient Date of Birth: _____

Relationship to Policyholder: Spouse Child Other Dependent

Additional Claim Information

Check all applicable boxes and ensure claim specific section below is complete.

- Standard Prescription
Complete page 1 and Claims Receipts section on page 2.
- Compound Prescription
- COVID-19 At-Home Test Kit
(No Medicaid or Medicare)
- Medicare Out-of-Network Purchase
- Medicare Part D Vaccine

Pharmacy Information

Pharmacy Name: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Pharmacy NPI: _____

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Capital Rx. Any assignment of these benefits must include an appropriate signature and is subject to Capital Rx's approval.

Signature _____ Date _____

Patient or Authorized Representative

Please note: If you are preparing this form on behalf of a member, please include a completed Personal Health Information Disclosure Form. For Medicare Part D members, please include a completed CMS-1696 form (Appointment of Representative form) or Personal Health Information Disclosure Form. Per CMS regulations, a purported representative may submit a completed CMS-1696 form or a form that includes the same information as the CMS-1696 form. Blank forms are available by visiting <https://www.cap-rx.com/members#member-forms>.



Mail completed form(s) with register receipts and other supporting documents to:
Capital Rx, Inc. Attn: Claims Dept. 9450 SW Gemini Dr., #87234, Beaverton, OR 97008.
You can also email all documents for processing to dmr@cap-rx.com.

Compound Prescriptions Only

Rx Number:		Prescription Fill Date:		Day Supply:	
Valid 11-digit Ingredient NDC:		Quantity	Ingredient Cost		
		Total Quantity			
		Total Charge			

- List the valid 11-digit NDC number for each ingredient used for the compound prescription.
- For each NDC number, indicate the metric quantity in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Include the total charge paid by the patient. (dollar amount)
- Receipts must be included with the completed claim form.

COVID-19 At-home Test Kits Only

Kit Name: _____ Number of Tests in Kit: _____ Purchase Date: _____

- Include the image of the COVID-19 At-Home Test Kit package with a visible barcode.
- Include register receipts with the date of purchase. Multiple line items on your receipt? Please circle or highlight the COVID-19 At-Home Test Kit line item for ease of processing.

Medicare Only: Out-of-Network Purchase

Please check the reason that best applies to your situation. Were any prescriptions filled because of:

Illness after traveling outside of the service area? Yes No

No network pharmacy within reasonable driving distance? Yes No

Medication not in stock at my network pharmacy? Yes No

Vaccine received at my doctor's office? Yes No

Federal emergency/natural disaster? Yes No

Medicare Only: Part D Vaccine Claim

Rx Number: _____
(if applicable)

Date Filled: _____ Vaccine Name: _____ NPI Number: _____

Total Paid for Vaccine: _____ Total Paid for Administrative Fee: _____

Vaccine NDC Number: _____ Prescribing Physician: _____

Prescribing Physician Address: _____

Is this a 2-part vaccine?: _____ 'Circle' Administered Location: Physician Office Clinic Pharmacy
(i.e., Shingrix)

Yes No

If yes, is this shot: First part in a series Second part in a series

Claim Receipts: Attach the original register receipt(s) and prescription information included with your prescription bag to this completed claim form. Please refer to the COVID-19 At-home Test Kit section for receipt requirements.

Register receipts or prescription information must include the following information. Please list the amount paid on the line provided.

- Prescription fill/purchase date
- Pharmacy name and address
- Prescriber name and prescriber NPI
- National Drug Code (NDC)
- Drug name, strength, and dosage form
- Prescription number (Rx number)
- Dispense as Written (DAW)
- Amount Paid \$ _____

Prescription Drug Claim Form Instructions



Please read carefully before completing the form.

- 1 Always present your member ID card at the participating retail pharmacy.
- 2 Use this form when you have paid full price for a prescription drug at a retail pharmacy.
- 3 You must complete a separate claim form for each pharmacy and patient.
- 4 You must submit within one (1) year of the date of service or as required by your plan.
For Medicare Only: Claims must be submitted within 36 months from the date of service.
- 5 For your request to be processed, all receipts must contain the information listed within this form. Your pharmacist can provide the necessary information if your claim or bill is not itemized. Please note that a cash register receipt is not sufficient.
For Medicare Only: Completion of the Prescription Drug Claim form is recommended but not required. You may submit equivalent written documentation, but it must provide all the requested information on this form. Please note that missing, incomplete, or hard-to-read documentation can delay the successful processing of your claim.
- 6 Incomplete forms may be returned or delay the process.
- 7 Please make copies of all documents for your records.
- 8 Reimbursement of submitted claims is subject to your prescription benefit program and is not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and will be for the amount your program would have paid on your behalf. The reimbursement amount may be significantly lower than the original amount you paid. Please remember that completing this form is not a reimbursement guarantee.

Insurance Fraud Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.