AdvancePCS℠
Prescription Drug Claim Form

SECONDARY COVERAGE

INSTRUCTIONS:

- This form should be used if you have primary prescription drug coverage with another insurance carrier.
- AFTER you have submitted your claim to the primary carrier:
  - Please provide all information requested.
  - Contact your pharmacist, if necessary, to provide the detailed drug information requested.
  - Rx receipt(s), EOB(s), or denial letter from primary insurer must be attached.
  - Use your AdvancePCS card to obtain your identification numbers.
  - Please use a separate claim form for each patient.

- **Do not staple or tape receipts or attachments to this form.**

- **Did you use another Prescription Drug Card when purchasing this prescription? Yes____ No____ If no, please attach the explanation of benefits (EOB) or Denial letter from your Primary Insurance Carrier.**

INSURED INFORMATION REQUIRED:

Insured's Name: _____
FIRST   MIDDLE   LAST

Street Address: _____

City: _____ State: ____ Zip: _____

Carrier #: ____   Group#: ____

ID #: _____   Patient ID Code: __

Employer/Company Name: _____

I certify that the information I have provided is correct and that the patient indicated below is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this claim form to AdvancePCS, and the plan administrator. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

PATIENT SIGNATURE: _____   EMPLOYEE SIGNATURE: _____

PATIENT INFORMATION REQUIRED:

Patient Name: _____ (LAST) _____ (FIRST)

Patient's Relationship to Insured:
Self ☐   Spouse ☐   Dependent ☐

Date of Birth: __ __ __   Male: ☐ Female: ☐

Check if Full-Time College Student _____

PHARMACY INFORMATION REQUIRED:

Pharmacy Name: _____   NABP #: _____   Phone: _____

Address: _____

City: _____ State: ___ Zip: _____   **PHARMACIST'S SIGNATURE**: _____

PRESCRIPTION CLAIM INFORMATION REQUIRED:

1 R #: _____ New or Refill (circle one) Date Filled : MONTH __ DAY __ YEAR ____   Quantity (ml., #tablets, gm., etc.) ____

Days Supply: ___   Name of Medication: _____   Prescriber DEA# _____

NDC#: _____   Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____   Tax: $ _____   Total Cost: $ _____

2 R #: _____ New or Refill (circle one) Date Filled : MONTH __ DAY __ YEAR ____   Quantity (ml., #tablets, gm., etc.) ____

Days Supply: ___   Name of Medication: _____   Prescriber DEA# _____

NDC#: _____   Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____   Tax: $ _____   Total Cost: $ _____

3 R #: _____ New or Refill (circle one) Date Filled : MONTH __ DAY __ YEAR ____   Quantity (ml., #tablets, gm., etc.) ____

Days Supply: ___   Name of Medication: _____   Prescriber DEA# _____

NDC#: _____   Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____   Tax: $ _____   Total Cost: $ _____

10886 (4/02)

Instructions

- Mail claim form, receipt(s), EOB(s), to: AdvancePCS, P.O. Box 52054, Phoenix, AZ 85072-2054

- If another prescription drug card was used to purchase the prescription:
  - Please circle the copay amount on the receipt.

- For Puerto Rico employees:
  - Please use the Puerto Rico location address as your own address on the front of this claim form:
    P.O. Box 100, Carolina, PR 00986-0100

- For your protection state law requires the following statement to appear on this form. 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 and civil penalties.

Compound Definitions

Compound - Any medication the pharmacist creates by mixing two or more ingredients, at least one of which is a prescription drug.

AdvancePCS Card Identification Numbers

Your AdvancePCS card may look like one of the representations below.

The top line of every AdvancePCS card indicates:

1) Carrier# (First set of four digits that identify your plan administrator)

2) Group # (Second set of four digits that identify your employer)

3) ID# (The last nine digits that identify the insured)

Certain AdvancePCS programs require an additional identification number:

4) Patient ID Code - a two digit number that identifies which family members are covered under your AdvancePCS program. If your card contains patient ID codes (see illustration), please indicate the two-digit patient ID code for the patient whom reimbursement is being requested. Place this code in the boxes provided on the front of this form.

```
1234 5678  123456789
PUBLIC
01JOHN  02JEANETTE
03MICHAEL  04JENNIFER
                    111111111
```

Field Definitions for the AdvancePCS card.

RXBIN - tells the pharmacy where to submit the claim

RXGRP - identifies your plan administrator. This number is also known as the Carrier Group number

ISSUER - is a unique business identification number

ID: identifies the enrollee

NAME: identifies enrollee that has prescription benefit coverage

```
RXBIN:    610415
RXGRP:    CCCCGGGG
ISSUER    (80840)
ID:       123456789
NAME:     01JOHN Q PUBLIC
02JEANETTE 03MICHAEL 04JENNIFER
```