BENECARD®

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Direct Reimbursement Claim Form

PART ONE: To be filled out by you

B X

MEMBER IDENTIFICATION NUMBER

PATIENT'S NAME

0 2 4 8 0 0 0 0

CUSTOMER NUMBER

/ /

PATIENT'S DATE OF BIRTH (MM/DD/YY)

MEMBER NAME

SEX: ☐ MALE ☐ FEMALE

RELATIONSHIP:
☐ SUBSCRIBER ☐ SPOUSE ☐ CHILD
☐ OTHER:

EXPLAIN

MEMBER MAILING ADDRESS

CITY STATE ZIP

( )

DAYTIME TELEPHONE

The undersigned certifies that the medication(s) described heron was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to the plan administrator, underwriter, sponsor, policy holder, employer, claim processor and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the undersigned's family members. The undersigned further authorizes use of such person's subscriber identification number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

X

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: To be filled out by you or your Pharmacist

PHARMACY NAME

STREET ADDRESS

PHARMACY NCPDP NUMBER

CITY STATE ZIP

( )

PHARMACY TELEPHONE

RX 1	RX 2
TAPE PHARMACY RECEIPT HERE	TAPE PHARMACY RECEIPT HERE
RX 3	RX 4
TAPE PHARMACY RECEIPT HERE	TAPE PHARMACY RECEIPT HERE

CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.

FOR COMPOUNDS

For Compounds: Pharmacist is to identify the specific prescription by date of service and RX number. Please list name, NDC# and metric quantities of each ingredient in box on left.

X

Signature of Pharmacist for Compounds

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INSTRUCTIONS

Claims submitted without the proper identification number from your *BeneRx*® ID Card will not be processed. Please be sure to copy your subscriber identification number exactly as it appears in your *BeneRx*® ID Card. If this is not done, the claim will be returned to you. To avoid undue delay, please complete all required areas of information on the claim form. Claims must be submitted within twelve months of the prescription purchase date.

HOW TO COMPLETE THIS FORM

PART ONE
Subscriber Information

1. Copy the 9 digit Subscriber Identification Number from your *BeneRx*® ID Card.
2. Subscriber name, address, and telephone number.
3. Patient Name: Person drug was prescribed for.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male of Female
6. Status: Patient's relationship to subscriber. If other, please write in type of relationship.
7. Please use separate claim form for each family member.

PART TWO
Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. Pharmacy NCPDP Number: Obtain the number from the pharmacy were prescription(s) were purchased.
3. Tape pharmacy receipts to the form in the space provided. The receipts must indicate date of service, Rx number, NDC number, quantity, days supply, and the amount paid. *Cash Register receipts are not acceptable.*
4. Use a **separate claim form** for each pharmacy from which you purchase prescriptions.

NOTE: Claims submission is not a guarantee of payment. You will only be reimbursed if the drug is covered by your plan and only for the amount that would have paid the participating pharmacy minus any applicable copayment.

ONCE COMPLETELY FILLED OUT, MAIL THIS FORM TO:

BeneRx®
Argus Health Systems
PO Box 419019, Dept. 248
Kansas City, MO 64141

IF YOU HAVE ANY QUESTIONS, CALL CUSTOMER SERVICE AT 1-800-479-0031.

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