CENTERS PLAN FOR HEALTHY LIVING

PART 1 **Denotes information required to process a claim. If this information is not included, it may delay or inhibit our ability to process your request for reimbursement.*

Primary Member/Cardholder ID Number*	Group Number	
Name of Health Plan/Insurance	Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Patient Name: (First, Middle, Last)*	Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber: Self ☐ Spouse ☐ Dependent ☐
Alternate Address: (Street, City, State, Zip code) ***If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.**		
Member Signature*	Telephone Number ( )	Date

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

☐ Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
☐ Discount Card was used
☐ Health plan/insurance information or insurance card not available at the time of purchase
☐ Pharmacy not participating in network
☐ Pharmacy unable to process claim electronically
☐ I was administered a Part D covered vaccine in my physician's office or clinic (cost for vaccine and administration fees must be listed separately)
☐ Emergency – If Emergency, describe emergency below

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PART 2

RX Number	Date Filled* / /	New ☐ Refill ☐	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name*:		Physician NPI*:
RX Price* $			Co-pay* $		Administration Cost* $

Compound? ☐Yes ☐No (If yes, please identify NDC ingredients & quantity on the Compound Claim Form)

PART 3: Affix Pharmacy Label Here or Populate the Information:

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