Pharmacy Claim Form

Patient information
Patient name:
Date of birth:
Address:
Phone number:
Email address:
Insurance ID number:
Group number (if applicable):
Pharmacy information
Pharmacy name:
Address:
Phone number:
License number:
Prescription information
Date of service:
Prescription number:
Medication name:
Strength:
Quantity:
Days supply:
Prescribing physician:
Phone number:
National drug code:

Claim information
Total amount paid:
Copay amount:
Amount to be reimbursed:
Reason for claim submission: ◯ Medication not covered ◯ Out-of-network-pharmacy ◯ Other (please specify):
Signature
I certify that the information provided is accurate and complete to the best of my knowledge. I understand that the submission of this claim is subject to verification.
Patient’s signature:
Date: