Prescription Drug Claim Form

Please complete all sections of the claim form below.

- Only one patient can be submitted per claim form.
- Copies of pharmacy receipts and register receipts must be included with submitted claim form.
- The pharmacy receipts must show the following prescription information for each expense:
  - Pharmacy Name and Address
  - Prescription Number
  - Drug Name, Strength, and NDC
  - Drug Cost
  - Patient Name
  - Fill Date
  - Quantity and Days-Supply
  - Amount Paid Out-of-Pocket
- Please mail or fax the completed form and accompanying receipts to:

  Magellan Health Services
  Attention: Claims Department
  P. O. Box 1599
  Maryland Heights, MO 63043

  Fax: 1-800-424-7578
- If you have any questions, please call your Customer Service area.

Please Note: This claim will not be processed until this form and accompanying receipts are submitted.

1. Policyholder or Insured's Name (First, Middle, Last): _____

   Street Address: _____

   City: _____ State: _____ Zip Code: _____
2. Policyholder or Insured's ID Number (as shown on ID card): _____
3. Why was the insurance or drug card not used for this purchase? _____
4. Patient's Name (First, Middle, Last): _____
5. Patient's Birth Date: _____
6. Patient's Sex: ☐ Male ☐ Female
7. Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other
8. Is the patient eligible for any other Prescription Drug Coverage? ☐ No ☐ Yes If YES, complete the following:

   8a. Does the coverage include: ☐ Major Medical ☐ Drug ☐ Other Medical

Insured's Name: _____ Insured's ID Number: _____

Insured's Birth Date: _____ Effective Date: _____

Insurance Company Name: _____

Address (Street, City, State, Zip Code): _____

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 Magellan Rx Management, its agents, or representatives.

Signature: _____ **Date:** _____

mrxinfo.com

Magellan Rx MANAGEMENT