CARRIER USE ONLY

APWU HEALTH PLAN

P.O. BOX 1358 GLEN BURNIE, MD 21060

PHONE: 800-222-APWU

PRESCRIPTION DRUG CLAIM FORM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. INSURED'S ID NUMBER

2. INSURED'S NAME & ADDRESS

(IF ADDRESS INCORRECT, PLEASE CORRECT ABOVE)

3. PATIENT (CHECK PATIENT'S NAME: ONLY ONE PATIENT PER CLAIM FORM)

4. PATIENT'S BIRTH DATE / /

5. PATIENT'S SEX CIRCLE: MALE FEMALE

6. PATIENT'S **APWU GROUP NUMBER** AS INDICATED ON YOUR PRESCRIPTION DRUG CARD (IF NOT INCLUDED ABOVE)

7. DOES PATIENT HAVE MEDICARE? IF YES, PLEASE INDICATE EFFECTIVE DATE AND ATTACH EOMB FROM MEDICARE CARRIER.

❑ PART "A" EFFECTIVE DATE _____ ❑ PART "B" EFFECTIVE DATE _____

8. IS PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE? YES ❑ NO ❑
IF YES, PLEASE INDICATE NAME OF POLICY HOLDER. PLAN NAME, ADDRESS, POLICY NO. AND PHONE NO. IF NO, PLEASE SIGN AND DATE.

IF YES, PLEASE ATTACH PAYMENT STATEMENT FROM OTHER CARRIER.

9. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT? YES ❑ NO ❑
IF YES, INDICATE FILE NO. _____
B. AN AUTO/MOTORCYCLE ACCIDENT? YES ❑ NO ❑ (PLEASE CIRCLE ONE)
IF YES, PLEASE ATTACH PAYMENT STATEMENT.

10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE AUTHORIZING THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED: _____ DATE: _____

CLAIMS FILING INSTRUCTIONS: Please Print

The member must complete and sign this form.

You must attach supporting receipts. Cancelled checks and balance due statements are not acceptable. Please list purchases in date order.

1. Non-prescription items and over-the-counter drugs are not covered.
2. **RX, NDC** (National Drug Code) and **NABP** (Pharmacy Identification) Numbers **are required.**
3. Claims must be submitted by December 31 of the year after the year you incur the expense. Failure to file within this limit will invalidate your claim.

Date of Purchase	Rx Number	NDC Number (11 Digits)	Brand or Generic Name of Drug	Days Supply	Qty.	Prescribing Physician	Drug Charge

I certify the Rx drugs listed were purchased for the patient named and **DO NOT** include drugs that can be purchased **OVER THE COUNTER** with or without a doctor's prescription.

Supplier's Federal Tax ID Number | Pharmacy NABP Number | Pharmacist's Signature

Pharmacy Name and Address

I certify the above statement to be correct.

Date | Member's Signature

WARNING: Any intentional false statement on this claim or willful misrepresentation relative thereto is a violation of the law, etc. (18 U.S.C. 1001).