

Please complete this form and submit with all required information and attachments to be considered for reimbursement. Do not submit claims for any prescription covered under Medicare, Medicaid, CHAMPUS, TRICARE or any state or federally funded programs, nor for any amount covered by insurance, FSA or HSA - none of which are eligible for payment.

Patient Information

Name (Last, First): _____, _____

Address (Street): _____ Date of Birth: - -

Apt./Suite No. _____ City: _____ State: Zip: -

Email: _____@_____ Phone: () _____ - _____ Fax: () _____ - _____

(Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)

Please refer to the Pharmacy Claim box, found on your card or printed offer, for the required information. It will look similar to the example shown (right).

BIN:	601341
PCN:	OHCP
Group:	OHXXXXXX
Member ID:	000000000000

Group:

Member ID:

Check this box if you are including a copy of your copay card or printed offer with this claim request to ensure accuracy.

Insurance Information

Do you have Health Insurance: No Yes and my insurer for prescription benefits is: _____

My insurance covered: This entire prescription None of this prescription All except copay of: \$ _____

This prescription was filled at a retail pharmacy store through mail order or specialty pharmacy (EOB required)*

***Specialty/Mail order claims require a copy of the Explanation of Benefits for this prescription from your insurance provider.**

Pharmacy Receipt

Mail this completed form along with the following items to the following address:

Attn: Claims Processing Department, IQVIA, Inc.
430 Mountain Ave., Suite 105, New Providence, NJ 07974

Failure to include any of the following will result in claim rejection:

1. The original pharmacy receipt received from your pharmacy with your Rx (see sample receipt, right) which must include the following information ():
 - ✓ Patient name and address
 - ✓ Pharmacy name, address and phone number
 - ✓ Doctor or health care provider name, address and phone number
 - ✓ Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity
 - ✓ Overall prescription price and Copay amount/out of pocket expense paid
2. Copy of your EOB (if required in Insurance Information section above)
3. The cash register receipt with the amount paid for this prescription clearly identified
4. Copy of your primary insurance card (including both front and back of the card)



Certification Statement

"I, _____, certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, CHAMPUS or any other government (state or federally funded) program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law."

Claimant/Patient/Legal Guardian Signature: _____ Date _____

Please allow 2 – 4 weeks for processing. This form can be used for multiple submissions.
For assistance completing this form, contact IQVIA, Inc. at 1-800-364-4767 and select the Patients option.