



Pharmacy Claim Form

Please include pharmacy receipt along with sales receipt for proper processing of your claim. Enrollee will only be reimbursed if acceptable proof of payment is submitted with claim. If pharmacy receipt is not included, please contact your pharmacist for the pharmacy and medication information with signature. Return this form with all receipts to: P.O. Box 930, Frederick, MD 21705.

Please circle your plan name: **M.D. IPA** **OPTIMUM CHOICE, INC.** **MAMSI** Life and Health Insurance Company

| Enrollee Information | | | |
|----------------------|------------|--|------------------------|
| Member Number | | Group Number | Social Security Number |
| Name (Last) | (First) | (M.I.) | Address |
| Date of Birth | Sex M/F | Relationship to Subscriber (circle one) Self / Spouse / Dependent Child | Telephone Number |

| Pharmacy Information | | | |
|----------------------|--|-------------------|------------------|
| Pharmacy Name | | Pharmacy NABP No. | Telephone Number |
| Street Address | | City | State ZIP |

| Medication Information | | | | | | |
|------------------------|-----------------|-----------------------|-----------------|----------|------------|-----|
| Rx Number | Medication Name | Medication NDC Number | Date of Service | Quantity | Day Supply | DAW |
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|--|-----------------|----------------------------|---------------|------------|-----|--|
| Is this a compounded medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please fill out below. | | | | | | |
| Rx Number | Medication Name | Date of Service | Quantity | Day Supply | | |
| Ingredients (Drug Name) | | NDC Number (if applicable) | Quantity Used | | DAW | |
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I hereby certify that the charge(s) shown for the medication(s) prescribed is (are) correct, and I agree to provide the Health Plan reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the enrollee.

Pharmacist Signature _____ Date _____

I hereby certify that the information I have given is accurate to the best of my knowledge, and that the medication received was not for an on-the-job injury. This information may also be used for other reporting and analysis purposes without identification of me or my family members. I recognize that reimbursement will be paid directly to me. I further recognize that reimbursement may be based on the maximum allowable cost of the medication, minus my copayment.

Enrollee Signature _____ Date _____

Subscriber Signature _____ Date _____