


Prescription Claim Reimbursement Request Form

IQVIA, Inc. / 77 Corporate Dr. / Bridgewater, NJ 08807 / Attn: Claims Processing Dept. Tel: 833-239-2611

Please complete this form and submit with all required information and attachments to be considered for reimbursement. Subject to combined annual limit of \$3,250. Reimbursement not available (i) for patients covered under Medicare, Medicaid, TRICARE, VA, DOD, or any other federal or state health care programs, (ii) where patient is not using insurance coverage at all, (iii) where patient's insurance plan reimburses for the entire cost of the drug, or (iv) where prohibited by law.

Patient Information																													
Name (Last, First): _____	Date of Birth: _____																												
Address (Street): _____	Apt./Suite No: _____																												
City: _____	State: _____ Zip Code : _____																												
E-mail: _____	Phone: _____ Fax: _____																												
(Your e-mail address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)																													
<div style="border: 1px solid black; padding: 5px;"> The required information can be found on your card as per the example shown (right) </div>	<table style="border: 1px solid black; width: 100%;"> <tr> <td style="padding: 2px;">BIN</td> <td style="padding: 2px;">601341</td> </tr> <tr> <td style="padding: 2px;">PCN</td> <td style="padding: 2px;">OHCP</td> </tr> <tr> <td style="padding: 2px;">GRP</td> <td style="padding: 2px;">OHXXXXXXXX</td> </tr> <tr> <td style="padding: 2px;">ID</td> <td style="padding: 2px;">XXXXXXXXXXXX</td> </tr> </table> <table style="width: 100%;"> <tr> <td style="width: 15%; padding: 5px;">Group#:</td> <td style="border: 1px solid black; text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> </tr> </table> </td> </tr> <tr> <td style="padding: 5px;">ID#:</td> <td style="border: 1px solid black; text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> </tr> </table> </td> </tr> </table>	BIN	601341	PCN	OHCP	GRP	OHXXXXXXXX	ID	XXXXXXXXXXXX	Group#:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> </tr> </table>									ID#:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> <td style="width: 12.5%; height: 20px;"> </td> </tr> </table>								
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<input type="checkbox"/> Check this box if you are including a copy of your co-pay card or printed offer with this claim request to ensure accuracy.																													
Insurance Information																													
Do you have Health Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes and my insurer for prescription benefits is: _____ My insurance covered: <input type="checkbox"/> This entire prescription <input type="checkbox"/> None of this prescription <input type="checkbox"/> All except co-pay of: \$ _____ This prescription was filled at <input type="checkbox"/> a retail pharmacy store, <input type="checkbox"/> through mail order or specialty pharmacy.																													
Pharmacy Receipt																													
Mail this completed form <u>along with the following items</u> to the following address: <div style="text-align: center; margin: 10px 0;"> Attn: Claims Processing Department, IQVIA, Inc. 77 Corporate Dr., Bridgewater, New Jersey 08807 </div> Failure to include any of the following will result in claim rejection: <ol style="list-style-type: none"> 1. The original pharmacy receipt received from your pharmacy with your Rx (see sample receipt, right) which must include the following information: <ul style="list-style-type: none"> ✓ Patient name and address ✓ Pharmacy name, address, and phone ✓ Doctor or health care provider name, address, and phone number ✓ Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity ✓ Overall prescription price and co-pay/out-of-pocket expense paid 2. The cash register receipt with the amount paid for this prescription clearly identified 																													
																													
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 insurance, a Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. I certify that the patient is not covered under Medicare, Medicaid, TRICARE, VA, DoD, or any other government (state or federally funded) program and that my use of this form is not prohibited by federal or state law. I understand and agree 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 at 1-833-239-2611.

