COMMERCIAL PRESCRIPTION DRUG CLAIM FORM

Kroger Prescription Plans

CLAIM FORM INSTRUCTIONS

Please read carefully before completing this form. **Claim forms without the required information cannot be processed and will be returned to sender.**

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1. The member/cardholder ID Number is located on your insurance card.
2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt Information

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form. Note: Please do not staple receipts or other documentation to the claim form.
3. For multiple claims, please submit a separate Part 2 for each medication or use the multiple prescription alternative form.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information.
Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 (509)555-1234
123 Any Street **Store NPI: 1234567890**
Home Town, US 12345-6789

RX 1234567 **Date Filled: 1/1/2009**

DOE, JANE
DOB: 01/01/1900
456 Home Road (509)555-5678
Home Town, US 12345

Amoxicillin 500 mg capsules (Teva) **DAW: 0**
00000-1111-22 **QTY: 45** **Days Supply: 30**

A. SMITH, MD
NPI: 4567890123

U&C: 200.00 **COPAY: 20.00**

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

**REQUIRED INFORMATION - CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED.*

Part 3: Pharmacy Information (To be completed by the pharmacy)

1. If required information is not available on the receipt, ask your Pharmacist to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records.
3. Send the completed form and receipt(s) to: MedImpact Healthcare Systems, Inc.
   PO Box 509098
   San Diego, CA 92150-9098
   Fax: 858-549-1569
   E-mail: Claims@Medimpact.com

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PART 1

***Indicates required information**

Primary Member/Cardholder ID Number*	Group Number	
Name of Health Plan/Insurance	Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Patient Name: (First, Middle, Last)*	Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber Self ☐ Spouse ☐ Dependent ☐
Primary Subscriber Address: (Street, City, State, Zip code)		
Alternate Address: (Street, City, State, Zip code) ***If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.**		
Member Signature*	Telephone Number ( )	Date

Indicate reason for manually filing these claims (select one):

- ☐ Coordination of Benefits – Claims must be submitted with pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
- ☐ Discount Card was used
- ☐ Health plan/insurance information or insurance card not available at the time of purchase
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency – If Emergency, describe emergency below

Manual submission of claims does not guarantee reimbursement.

Describe Emergency: _____

PART 2

RX Number	Date Filled* / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength *	Physician Name & NPI Number Name: _____ NPI : _____		RX Price* $	Co-Pay* $	

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled * / /	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength *	Physician Name & NPI Number Name: _____ NPI : _____		RX Price* $	Co-Pay* $	

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			NPI*	
City	State	Zip	Pharmacist Signature*	Date*

COMPOUND PRESCRIPTIONS

*** Pharmacy or dispensing facility must complete the remaining portion and return this to member**

- Enter the NDC number of the MOST expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the metric quantity dispensed in number of tablets, grams or mls for liquids, creams, ointments, and injectables.
- Indicate the amount paid for the prescription by the patient.

COMPOUND PRESCRIPTIONS *For pharmacy use only			
NDC#	**Drug Ingredient**	**Quantity**	**Charge**
		Total Charge:	$

Note: If purchased in a foreign country, the currency must be converted into US dollars.

- The original paid pharmacy prescription label/receipt (including the required drug information) MUST accompany this claim form. Pharmacy receipts will not be returned, you may wish to make copies for your records.

IMPORTANT CLAIM NOTICE

AL, AK, AZ, CT, DE, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OR, RI, SC, SD, VT, WI, WY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties. **Additionally, DE, ID, MN, NM, OH Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or criminal penalties.

AR, CA, DC, FL, HI, MD, ME, OK, TN, TX, UT, VA, WA, WV Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be subject to imprisonment, fines, and/or denial of insurance benefits. **Additionally, AR, CA, FL, MD, OK, TX, UT, WV Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or confinement in prison.

CO Residents: WARNING – For your protection, state law requires the following statement to appear on this form. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department or regulatory agencies.

NY Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PA Residents: WARNING – For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.

Puerto Rico Residents: WARNING – For your protection, we are required to print the following. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefits, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollar ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.