

MEDICA Pharmaceutical Prescription Claim Form

Medica Health Plans of Wisconsin – Medica Insurance Company
Medica Health Plans – Medica Self-Insured

Mailing Address:
10680 Treena Street, 5th Floor
San Diego, CA 92131
952-945-8000 or 800-952-3455
TTY National Relay Center: 1-800-855-2880

Member/Subscriber Name _____
(Please Print) First Name Middle Last Name

Member/Subscriber ID # _____ **Group/Policy Number** _____
(Required) (This may include social security number) (5 or 6 digits, not the payer ID)

Patient's Address: _____ **City** _____ **State** _____ **ZIP** _____
Street Address

Daytime Phone (including area code) _____ Evening Phone (including area code) _____

Prescriptions Were Dispensed To:

Patient Name _____
(Required) First Name Middle Last Name

Note: Use a separate claim form for each covered member of the family.

Patient Birth Date _____ **Age** _____ Male Female **Relationship to Subscriber:** Self Spouse Child

Is this medication for an on-the-job injury? Yes No

Is this medication covered under any other group insurance plan? Yes No

If "yes," give insurance company name, address, member's name and group policy number:

Name of Insurance Company

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Signature _____
Member/Subscriber

Please attach the duplicate pharmacy generated receipt to this form. If receipt does not give full MD name, please write it in the section below along with Medical Doctor's DEA#. (You may need to contact the doctor's office to obtain.) If receipt is unavailable, please have the pharmacy or dispensing facility complete the section below.

PHARMACY OR DISPENSING FACILITY NEEDS TO COMPLETE THE REMAINING PORTION AND RETURN THIS TO MEMBER.					
Rx Number	Date Filled	Quantity	MD Full Name	Days Supply	Rx Price w/Tax
Medication Name, Form and Strength		DAW	MD DEA # (Required)	NDC Number (11 digits)	
Rx Number	Date Filled	Quantity	MD Full Name	Days Supply	Rx Price w/Tax
Medication Name, Form and Strength		DAW	MD DEA # (Required)	NDC Number (11 digits)	
Rx Number	Date Filled	Quantity	MD Full Name	Days Supply	Rx Price w/Tax
Medication Name, Form & Strength		DAW	MD DEA # (Required)	NDC Number (11 digits)	

If purchased in a foreign country, the currency must be converted into U.S. dollars. Diagnosis and description of the drug is also required for claim processing.

Claims submitted with missing required information, including medical doctor's DEA #, may result in the claim being returned unprocessed. The claim will need to be re-submitted with the missing information filled out in order to process.

Pharmacy Name _____ **Pharmacy NABP (Required)** _____

Address _____ **Pharmacy Phone** _____

City _____ **State** _____ **ZIP** _____ **Pharmacist's Signature** _____
Certification: My signature above certifies that the above prescription(s) have been dispensed as recorded.

AUTHORIZATION: On behalf of myself and any patient named on this claim form ("Us") I authorize any health care professional or entity, employer, union insurance company, health maintenance organization, other plan company or prepayment organization to give Medica Health Plans, Medica Insurance Company, Medica Health Plans of Wisconsin or Medica Self-Insured and my employer, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for evaluation of this claim, and for any analytical or research purposes and to allow Medica Health Plans, Medica Insurance Company, Medica Health Plans of Wisconsin and Medica Self-Insured to release such information or records as necessary for administration, analytical or research purposes or in compliance with any state and federal laws. This authorization will automatically expire one year following the date of signature without my express revocation.

Signature _____ **Date** _____