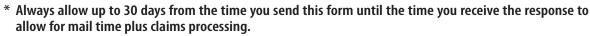




Prescription Reimbursement Claim Form

Important!





* Keep a copy of all documents submitted for your records.
* Do not staple or tape receipts or attachments to this form.

STEP 1 Card Holder/Patient Information	This section must be fully completed to ensure proper reimbursement of your claim.
Card Holder Information	
dentification Number (refer to your prescription card)	Group No./Group Name
Name (<i>Last Name</i>)	(First Name)
Address	
ity	State Zip
	State Zip
Patient Information—Use a separate claim	n form for each patient.
Name (<i>Last Name</i>)	(First Name) (MI)
Date of Birth Male Fema	ale Phone Number
Relationship to Primary member	Del
Member Spouse Child C	Other
Other Insurance Information	
COB (Coordination of B	Panafite)
Are any of these medicines being taken for	
Is the medicine covered under any other grou	•
If yes, is other coverage: O Primary O Second If other coverage is Primary, include the explar	
Name of Insurance Company	ID #
Important! A signature is REQUIRED	
	NOTICE
Any person who knowingly and with intent to	defraud any insurance company or other person files an application for y materially false information or conceals for the purpose of misleading
information concerning any fact material thei	reto commits a fraudulent insurance act, which is a crime and subjects
such person to criminal and civil penalties.	
I certify that I (or my eligible dependent) hav	e received the medicine described herein and that the plan participan
iob injury or covered under another benefit o	lso certify that the medicine received is not for treatment of an on-the lan. I certify that I have read and understood this form, and that all the
information entered on this form is true and co	orrect.
x	
Signature of Plan Participant	Date

Submission Requirements: You MUST include all orginal receipts in order for your claim to process. Cash register receipts will only be accept

iou Mosi	IIICIuue	an orginal	receibrs iii o	nuer ior yo	ui ciaiiii tu	process.	casii register	receipts will	oniy be accept	teu ioi
diabetic s	upplies.	The minim	um informa	tion requir	ed is:					

Patient Name
 Date of Fill
 Prescription Number
 Medicine NDC number
 Days Supply

• Total Charge • Pharmacy Name and Address or Pharmacy NABP Number

f Foreign Claim: Country:	Currency:	Amount:
	carrency:	

STEP 3 Mailing Instructions:

NALC Prescription Benefit Program P.O. Box 52192 Phoenix, Arizona 85072-2192

IMPORTANT REMINDER

To avoid having to submit a paper claim form:

- Always have your card available at time of purchase
- Always use pharmacies within your network
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card .