



Please mail this claim form directly to:

NMHC Rx- DMR
9343 Tech Center Dr., Ste 200
Sacramento CA 95826-2592

**CARDHOLDER PRESCRIPTION
 DRUG CLAIM FORM**

For assistance please call:
(800)-777-0074 or (916)361-4400
 Mon-Fri 5:30am to 7:00pm
 Saturday: 6:00am to 5:00pm
 Pacific Standard Time

Please print or type this information

Group#	<input type="text"/>	I.D. #	<input type="text"/>
Plan/Employer Name:			
Cardholder's Last Name	First Name:	Middle Initial	
Cardholder's Street Address:	City:	State:	Zip:
()	()	-	-
Cardholder's Day Time Phone Number:	Cardholder's Evening Phone Number:		
Patients Name: (Use a separate claim form for each covered family member)		Patients Date of Birth	
<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
<small>Patients Sex</small>		<small>Patient's relationship to cardholder</small>	
<input type="checkbox"/> Child	<input type="checkbox"/> Other		

THE BELOW AREA MUST BE COMPLETED. YOUR PHARMACIST MAY ASSIST YOU IN COMPLETING .

Pharmacy NCPDP#: _____ Pharmacy Name: _____

Prescription Information (Your pharmacy label receipt has the following information) Please attached copies to the back of this form.

1	Fill date _____ RX# _____	Quantity _____	Day Supply _____
	Drug Name _____	Drug Strength: _____	
	NDC # _____	Doctors Name: _____	
	Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____		
Amount to Be Reimbursed. \$ _____			
2	Fill date _____ RX# _____	Quantity _____	Day Supply _____
	Drug Name _____	Drug Strength: _____	
	NDC # _____	Doctors Name: _____	
	Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____		
Amount to Be Reimbursed. \$ _____			
3	Fill date _____ RX# _____	Quantity _____	Day Supply _____
	Drug Name _____	Drug Strength: _____	
	NDC # _____	Doctors Name: _____	
	Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____		
Amount to Be Reimbursed. \$ _____			

Date: _____ Employee's Signature _____

ILLEGIBLE OR INCOMPLETE CLAIM MAY CAUSE DELAY IN PAYMENT. WE CAN NOT PROCESS THIS FORM WITHOUT THE ABOVE INFORMATION. THANK YOU FOR YOUR COOPERATION.

CARDHOLDER PRESCRIPTION DRUG CLAIM FORM (Continued)

Group#	<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>					I.D. #	<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>																				

YOUR PHARMACIST MAY ASSIST YOU IN COMPLETING THE SECTION BELOW. Prescription Information (Your pharmacy label receipt has the following information) Please attached copies to the back of this form.

4	Fill date _____ RX# _____ Quantity _____ Day Supply _____ Drug Name _____ Drug Strength: _____ NDC # _____ Doctors Name: _____ Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____ Amount to Be Reimbursed. \$ _____
5	Fill date _____ RX# _____ Quantity _____ Day Supply _____ Drug Name _____ Drug Strength: _____ NDC # _____ Doctors Name: _____ Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____ Amount to Be Reimbursed. \$ _____
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7	Fill date _____ RX# _____ Quantity _____ Day Supply _____ Drug Name _____ Drug Strength: _____ NDC # _____ Doctors Name: _____ Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____ Amount to Be Reimbursed. \$ _____
8	Fill date _____ RX# _____ Quantity _____ Day Supply _____ Drug Name _____ Drug Strength: _____ NDC # _____ Doctors Name: _____ Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____ Amount to Be Reimbursed. \$ _____
9	Fill date _____ RX# _____ Quantity _____ Day Supply _____ Drug Name _____ Drug Strength: _____ NDC # _____ Doctors Name: _____ Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____ Amount to Be Reimbursed. \$ _____
10	Fill date _____ RX# _____ Quantity _____ Day Supply _____ Drug Name _____ Drug Strength: _____ NDC # _____ Doctors Name: _____ Did another insurance plan cover this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Insurance _____ Amount to Be Reimbursed. \$ _____

Questions? Call

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Revised 11/30/05