Pharmacy Prescription Claim Reimbursement Form

IQVIA, Inc. 77 Corporate Dr. Bridgewater, NJ 08807 Attn: Claims Processing Dept.
Tel: 1-800-364-4767 Fax: 1-908-548 9293 Email: claim.support@IQVIA.com

Please complete this form and submit with all required information and attachments to be considered for reimbursement. Subject to combined annual limit of [$18,000]. 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): _____, _____

Address (Street): _____ **Date of Birth:** ☐☐-☐☐-☐☐

Apt./Suite No. _____ **City:** _____ **State:** ☐☐ **Zip:** ☐☐☐☐☐ ☐☐☐☐

Email: _____@_____ **Phone:** ( ) _____ - _____ **Fax:** ( ) _____ - _____

(Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)

The required information can be found on your card as per the example shown (right)

Group#: O H ☐☐☐☐☐☐☐☐☐

ID#: ☐☐☐☐☐☐☐☐☐☐☐☐☐

[ ] 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: [ ] No [ ] Yes and my insurer for prescription benefits is: _____.
My insurance covered: [ ] This entire prescription [ ] None of this prescription [ ] All except co-pay of: $ _____.
This prescription was filled at [ ] a retail pharmacy store, [ ] through mail order or specialty pharmacy.

Pharmacy Receipt

Mail this completed form along with the following items to the following address to the address, fax, or email above:

Failure to include any of the following will result in claim rejection:

1. The original pharmacy receipt received from your pharmacy with your Rx (see sample receipt, right) which must include the following information:
   - ✓ 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


RECEIPT
ANY PHARMACY, INC
100 Main St.
Anytown, NY 12345
Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788 OFI
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED
DR.JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE,NY 11788
AA0000000 (631)582-6787
RxPrice:$XXX.XX
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

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 Mayzent Claim Reimbursement Program at 1-800-364-4767.

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