

Pharmacy Direct Reimbursement Claim Form

If this is an urgent request, please call Together with CCHP Pharmacy Services at 1-844-201-4677
 Otherwise please return completed form to Together with CCHP Pharmacy Services by fax at 1-844-201-4675

Member Information

PATIENT NAME (LAST, FIRST, MI)	DATE OF BIRTH	GENDER	F M	MEMBER ID NO.
STREET PLEASE CHECK IF NEW ADDRESS:	CITY	STATE	ZIP	DAYTIME PHONE
PLAN NAME / PLAN TYPE	GROUP NUMBER			
Is Together with CCHP the patient's primary coverage?				Yes No
Does the patient have primary coverage under another plan?				Yes* No

*If yes, please attach an explanation of benefit from your primary carrier.

Prescription Information

Important – All prescription claims must have prescription receipts / labels which includes:

- | | | |
|--------------------|-------------------------------|---------------|
| • Patient's Name | • Date Filled | • Price |
| • Pharmacy Name | • Drug Name, Strength and NDC | • Quantity |
| • Pharmacy Address | • Script number | • Days supply |

Please note that the above claim detail information is necessary in order to process your claim request.

Remember:

- Please tape receipts to separate piece of paper
- Cash register receipts **are not** acceptable for any prescription (with the exception of diabetic supplies).

Diabetic Supply

- | | | |
|---|--------------------------|---------------|
| • Is the claim for diabetic supply? | Yes | No |
| • Please make sure receipts include: | | |
| ○ Patient's Name | ○ Date filled | ○ Quantity |
| ○ Pharmacy Name | ○ Type of insulin and/or | ○ Days supply |
| ○ Pharmacy Address | type of supply | ○ Price |
| • Cash register receipts are acceptable but Pharmacist Signature is required if any information is handwritten. | | |

Diabetic Supply

- | | | |
|--|------|----|
| • Is the claim for allergy serum or vaccination? | Yes* | No |
| *If yes, please supply type or additional information. | | |

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Signature

I certify that all information provided is correct and that the prescription(s) submitted are for me. I have received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc., the company chosen by my Plan Sponsor to manage my pharmacy benefit, and my Plan Sponsor. Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

PATIENT'S SIGNATURE

DATE

Reimbursements can be mailed to:

Pharmacy Services Department

U.S. Steel Tower, Floor 12

600 Grant St.

Pittsburgh, PA 15219