Fallon Health and Fallon Health & Life Assurance Co., Inc.

Request for Payment of Pharmacy Services

Request for payment to:

❑ Subscriber ❑ Member (Proof of payment must be included; see reverse.)

MEMBER INFORMATION

First name	Middle initial	Last name	Date of birth MM/DD/YYYY
Street			
City		State	ZIP
Member ID number	Home telephone ( )	Work telephone ( )	Sex ❑ Male ❑ Female

PRESCRIPTION INFORMATION *(See your prescription label for details.)*

Please note that we cannot process your request unless this entire section is completed.

Date filled MM/DD/YYYY	Days supply *(ask your pharmacist for this information)*	
Rx number	Metric quantity	
NDC number		
Prescribing physician name	Prescriber NPI number	
Prescriber street address	**Charge**	**Amt. paid**
City		
State / ZIP / Prescriber telephone ( )		
Pharmacy name and address or pharmacy NABP number	**Total**	**Total**

OTHER INSURANCE

Is member covered by other insurance? ❑ Y ❑ N If yes, number: _____

If yes, name and address of carrier _____

Is the claim due to

an automobile accident? ❑ Y ❑ N Please explain: _____

any other type of accident? ❑ Y ❑ N Please explain: _____

the result of an occupational injury or illness? ❑ Y ❑ N

Comments: _____

SUBSCRIBER INFORMATION ❑ Check if same as above.

Subscriber's name	
Subscriber's address	
City, State, ZIP	
Home telephone ( )	Work telephone ( )

AUTHORIZATION RELEASE

I, the undersigned, hereby authorize any physician, hospital, insurer, or other organization or person having any medical or other records, data or information concerning me or my minor dependent to furnish such records, data or information to Fallon Health. I understand that in executing this authorization, I waive all claim and right of privilege with regard to such information. A photocopy of this authorization shall be considered as effective and valid as the original bearing my signature.

Subscriber signature _____ Date _____

Patient signature _____ Date _____
(if other than insured or minor)

See reverse for instructions.

Instructions for submitting your Request for Payment of Pharmacy Services

Follow these easy steps:

1. **Include** some proof of payment such as a canceled check or paid receipt. Please don't use tape or a staple. Remember to make a copy for your records.

2. **Complete** the "Member Information" section showing your name, member ID number and other identifying information.

3. **Complete** the "Prescription Information" section.
   Include your pharmacy receipt and label from your prescription bag with this form. If you no longer have this information, please contact the pharmacy and they can provide you with a printout.
   Please note: cash register receipts will only be accepted for diabetic supplies.

   If you are requesting reimbursement for a compounded medication, you will need to complete the attached Compound Prescription Form. Bring it to your pharmacy and they can help you complete it.

4. **Complete** the **"**Other Insurance**"** section providing all information on other health insurance (if applicable), automobile accident, other accident or occupational illness/injury (workers' compensation).

5. **Complete** the "Subscriber Information" section.

6. **Sign and date** the Authorization Release.

With complete information, payment will be received within 30 days. We will contact you in writing if we need additional information regarding your claim.

After completing the form, please mail it with receipts to:

CVS/caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

If you have any questions, please call Customer Service at the phone number on the back of your member ID card.

To receive payment, forms must be submitted to CVS/caremark within one year of the date of service.

fallonhealth

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& life assurance company, inc.

COMPOUND PRESCRIPTION FORM

- A compound prescription must contain more than one ingredient.
- List the VALID 11-digit NDC number for EACH ingredient used in the compound prescription.
- List the ingredient name for each NDC.
- Indicate the "metric quantity" expressed in number of tablets, grams or milliliters for each ingredient NDC #.
- Indicate the cost for EACH ingredient (dollar amount).
- Indicate the TOTAL compounded quantity.

Rx #	11-digit NDC #	Ingredient Name	Metric Quantity	Ingredient Cost

Total Metric Quantity	
Total Amount Paid by Patient	

Rx #	11-digit NDC #	Ingredient Name	Metric Quantity	Ingredient Cost

Total Metric Quantity	
Total Amount Paid by Patient	

Rx #	11-digit NDC #	Ingredient Name	Metric Quantity	Ingredient Cost

Total Metric Quantity	
Total Amount Paid by Patient	