MC-Rx
Powered by ProCare Rx

Prescription Drug Claim Form

When Completed Return To:
MC-Rx PBM
Attn: Claims Reimbursement
1267 Professional Parkway
Gainesville, GA 30507
Phone: (678) 248-3100
Fax: (678) 248-3170
Websites: https://www.mc-rx.com/

A. – Insured / Patient Information:

Cardholder's Last Name / First Name / Middle Initial	Plan Name	Cardholder Identification Number	Today's Date
			/ /

Address

City, State, ZIP

Telephone:
Home: ( ) - Work: ( ) -

Mailing Address (Patient's Address if payment should be mailed to a different address than above for Cardholder)

City, State, ZIP (Patient's Address if payment should be mailed to a different address than above for Cardholder)

Patient's Last Name / Patient's First Name / Middle Initial	Date of Birth	Patient's Sex	Relationship to Cardholder
	/ /	☐ Male ☐ Female	☐ Self ☐ Dependent ☐ Spouse ☐ Other

Employer Name	Group Number

Employer Address, City, State, Zip

Do you or any member of your immediate family have other group insurance which may cover all or part of this claim?	If yes, give the insurance company name and group number:
Primary Coverage: ☐ Yes ☐ No Secondary Coverage: ☐ Yes ☐ No	

B. – Claim Information: Important – Submit either Prescription receipts / labels or patient history print-out from your Pharmacy

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number:	Metric Quantity
		/ /		
Days Supplied	NDC#	Prescriber		Charge

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number:	Metric Quantity
		/ /		
Days Supplied	NDC#	Prescriber		Charge

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number:	Metric Quantity
		/ /		
Days Supplied	NDC#	Prescriber		Charge

Pharmacy ID#	Pharmacy Name	Fill Date	Rx Number:	Metric Quantity
		/ /		
Days Supplied	NDC#	Prescriber		Charge

C. – Reason for Claim Submission or Special Notes:

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D. – Authorization:

I certify that the above information is true and correct to the best of my knowledge and hereby authorize any physician, pharmacy, employer, union, insurance company or HMO to supply any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

X______________________________________ ______________________
Insured's Signature Date Signed

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND FILL OUT REVERSE SIDE OF THIS FORM.

SECTION A – INSURED / PATIENT INFORMATION: (Complete this section for each family member who has received medication)

1. Print Cardholder's name (last, first, middle initial)
2. Print Cardholder's Identification Number (found on prescription drug or health insurance card)
3. Print Today's Date
4. Print Cardholder's Address Information and Phone Numbers
5. Print Mailing Address (Patient's address, if payment should be mailed to a different address than the Cardholder's address above)
6. Print Patient's name (last, first, middle initial)
7. Patient's Date of Birth, Patient's Sex and Check Relationship to Cardholder (Self, Spouse, Dependent, Other)
8. Print Employer Name, Group Number and Employer Address information (refer to drug or health insurance card)
9. Indicate if covered under another drug plan, include the insurance company name and group number

SECTION B – CLAIM INFORMATION:

Submit either prescription receipts/labels with this claim form or a patient history printout from your pharmacy. It is preferable to have them unattached. Please do not staple, tape, or glue.

Claims received missing any of the following information may be returned or payment may be denied:

- Pharmacy ID# -- 7-digit Pharmacy Identifier (NABP#)
- Pharmacy Name – Pharmacy Name
- Fill Date – Date drug was dispensed
- Rx Number – Prescription Number
- Metric Quantity – Quantity of the drug dispensed
- Days Supply – The number of days supply of the drug dispensed
- NDC # -- 11-digit drug code
- Prescriber – Prescribing physician's name
- Charge - Amount paid for the prescription

Note: Altered receipts require pharmacist's signature.

SECTION C – REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

This section can be used for special notes or comments.

SECTION D – AUTHORIZATION:

Insured's Signature and Date Signed

IMPORTANT: Claim form must be signed. (Unsigned claim forms cannot be processed and will be returned)

Questions? Call MC-Rx PBM Customer Service Department at (1-855-828-1484)

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