



**Prescription Drug Program  
Subscriber Reimbursement Form**

**SUBSCRIBER INFORMATION**

PLEASE PRINT

SUBSCRIBER NAME (Last Name, First Name)		SUBSCRIBER I.D. NO.			GROUP NO.	PLAN CODE
PATIENT'S FIRST NAME	DOES PATIENT HAVE OTHER DRUG COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	PATIENT'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		PATIENT DATE OF BIRTH MO DAY YEAR
MAILING ADDRESS OF SUBSCRIBER (Number and Street)			PLEASE CHECK IF NEW ADDRESS <input type="checkbox"/>	CITY	STATE	ZIP CODE
I CERTIFY THAT THE PATIENT FOR WHOM THIS CLAIM IS MADE IS A COVERED PERSON IN THIS PRESCRIPTION DRUG PROGRAM AND THAT THE PRESCRIPTION IS FOR THE SOLE USE OF THE NAMED PATIENT. I ALSO CERTIFY THAT THE CLAIM(S) BEING SUBMITTED FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT AUTOMOBILE OR WORKER'S COMPENSATION INSURANCE PROGRAM. (Subscriber/Authorized Representative) X _____ (Date) _____						

**PRESCRIPTION INFORMATION**

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
1				<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL DRUG CODE		QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN		PRESCRIPTION PRICE Including All Discounts
LABEL BRAND	PRODUCT NO.					
						\$
DIAGNOSIS		N.A.B.P. PHARMACY NO.	NAME AND ADDRESS OF PHARMACY			

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
2				<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL DRUG CODE		QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN		PRESCRIPTION PRICE Including All Discounts
LABEL BRAND	PRODUCT NO.					
						\$
DIAGNOSIS		N.A.B.P. PHARMACY NO.	NAME AND ADDRESS OF PHARMACY			

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
3				<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL DRUG CODE		QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN		PRESCRIPTION PRICE Including All Discounts
LABEL BRAND	PRODUCT NO.					
						\$
DIAGNOSIS		N.A.B.P. PHARMACY NO.	NAME AND ADDRESS OF PHARMACY			

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
4				<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL DRUG CODE		QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN		PRESCRIPTION PRICE Including All Discounts
LABEL BRAND	PRODUCT NO.					
						\$
DIAGNOSIS		N.A.B.P. PHARMACY NO.	NAME AND ADDRESS OF PHARMACY			

CLAIM NUMBER	FOR OFFICE USE ONLY	Rx NUMBER	DATE Rx FILLED	NEW	REFILL	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer, if Compounded Rx complete reverse side.)
5				<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL DRUG CODE		QUANTITY	DAYS SUPPLY	NAME OF PRESCRIBING PHYSICIAN		PRESCRIPTION PRICE Including All Discounts
LABEL BRAND	PRODUCT NO.					
						\$
DIAGNOSIS		N.A.B.P. PHARMACY NO.	NAME AND ADDRESS OF PHARMACY			

**INSTRUCTIONS**  
**WHEN TO USE THIS FORM**

This form should be used to obtain reimbursement if you did not have your identification card at the time your prescription was filled, or because the pharmacy which filled your prescription was a non-participating pharmacy.

Submit this form as soon as you have your prescription(s) filled in order to receive prompt payment. It IS NOT necessary to retain this form until you have filled in five prescription claims.

**HOW TO COMPLETE THIS FORM**

**SUBSCRIBER INFORMATION**

1. Complete the upper portion of the claim form under SUBSCRIPTION information. Transfer the **subscriber identification number** and **group number** from your prescription drug or health insurance identification card or your enrollment application.
2. A separate claim form must be completed **for each patient**.

**PRESCRIPTION INFORMATION**

1. Have your pharmacist complete the PRESCRIPTION information for each prescription filled. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or receipt.
2. The **original paid** pharmacy receipt (including the required drug information) MUST accompany this form. Copies are not acceptable. Since pharmacy receipts cannot be returned, you may wish to make copies for your records. Personal itemizations, tax statements, cash register tapes, and cancelled checks are not acceptable receipts.

**IMPORTANT:** The drug quantity and both the drug name and strength OR National Drug Code is required and **MUST** appear on the submitted claim(s) or receipt(s).


3. — **FOR COMPOUNDED PRESCRIPTIONS ONLY** — If your pharmacist tells you this is a compounded prescription, you must complete the area below. Ask your pharmacist for assistance. Should you have more than two compounded prescriptions, please use additional claim forms.

CLAIM #	COMPOUND INGREDIENTS		
	DRUG NAME	QTY.	COST

CLAIM #	COMPOUND INGREDIENTS		
	DRUG NAME	QTY.	COST

**WHERE TO MAIL THIS FORM**

Mail this form and your original **paid** pharmacy receipt(s) to:

  
UNICARE • Life and Health Insurance Company  
P.O. Box 9085  
Oxnard, CA 93031-9085  
Attn: Claim Services

Unicare® is a registered mark of WellPoint Health Networks Inc.

**NOTICE**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any factual material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.