Uniform Medical Plan Prescription Drug Claim Form

This claim form can be used to request reimbursement of covered prescription drugs. This form includes standard reimbursement requests, as well as requests for Compound Drugs. If your prescription drug is not a compound, some of the requested information may not be applicable. **Allow up to two weeks for processing after we receive your claim.**

Indicate the reason for your reimbursement request.

☐ I did not have my member ID card at the time of purchase.
☐ Primary coverage is with another insurance carrier.
☐ Other: _____

Part 1: Member Information

1. Complete **ALL** information. Your ID Number is on the front of your member ID card.
2. Submit claims within the filing period. For questions about your filing period, review your UMP certificate of coverage or call Washington State Rx Services (WSRxS) Customer Service at 1-888-361-1611 (TRS: 711).
3. Submit a separate form for each person for whom you are submitting receipts.
4. Reimbursement will be made directly to the primary subscriber unless otherwise noted.

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number W_____	Subscriber's Employer (PCN) **Uniform Medical Plan Public Employees Benefits Board (PEBB) - NVTU** **Uniform Medical Plan School Employees Benefits Board (SEBB) - NVTU**	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information

1. Complete **ALL** information.
2. Submit a separate form for each pharmacy from which you purchased prescription drugs.

Pharmacy Name		
Street Address		
City	State	ZIP Code
Pharmacy/or Provider of Service National Provider Number (NPI) (can be obtained from pharmacy)		Telephone Number ( )

Part 3: Receipt Information

1. Include Proof of Payment with the original pharmacy receipt(s)or pharmacy printout(s). Receipt(s) without pharmacy detail will not be accepted. Tape all receipt(s) to the bottom of this page. **DO NOT** staple.
2. Receipt(s) must contain the information outlined under Part 4. If your receipt(s) are missing any of this information, have your pharmacy provide you with a pharmacy receipt or pharmacy printout, that includes this information.
3. If you have primary coverage with another insurance carrier, provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier.
4. An incomplete form may be denied, delayed, or returned.
5. Receipts will not be returned. **Remember to keep a copy of the completed claim form and receipt(s) for your records.**

Part 4: Prescription Drug Information: *This information should be listed in your original pharmacy receipt, or pharmacy printout. If the receipt or invoice is missing any of this information, ask your pharmacy to help fill in the missing details. If you are unable to obtain the information, we will attempt to contact your pharmacy. If you have more than one prescription, submit a separate "Part 4" for each medication.*

Prescription Drug Name		
Date Rx Filled	Quantity	Day Supply
Rx Number	National Drug Code (NDC)	
Prescriber First/Last Name		Prescriber NPI (Ask your provider)
Original Cost of Rx	If there is other coverage for this member, provide the amount the Primary Insurance Paid on Rx	Member Paid Amount

Part 5: For Compounded Prescriptions only

1. The information in this section should be filled out by your compounding pharmacy.
2. **Note to Compounding Pharmacy:** It is important to include the **preparation time** below. Omission of the preparation time may result in a lower reimbursement.

Select the final form of Compound:		
☐ Cream ☐ Liquid ☐ Ointment	☐ Patch ☐ Suppository ☐ Suspension	☐ Other (Please specify): _____
Total Volume (grams, ml, each, etc.)		

Compound Ingredients

	Ingredient Name	Ingredient NDC	Metric Decimal Quantity	AWP/WAC (Ingredient Cost)
1				
2				
3				
4				
			Total Ingredient Cost	
			Preparation Time* (in minutes)	

***Compounding pharmacy preparation time spent preparing the compound drug**

Time	Reimbursement
1 – 4 minutes	$15.00
5 – 14 minutes	$25.00
15 – 29 minutes	$35.00
30 - 59 minutes	$50.00
60+ minutes	$75.00

1. **Prescription drugs purchased from any pharmacy, except CVS.**

Mail this form along with receipt(s) to:

Pharmacy Manual Claims

PO Box 999
Appleton, WI 54912-0999

Or Fax this form along with receipt(s) to:

Toll Free 1-855-668-8550