Prescription Paper Claim Form

National Pharmaceutical Services

1. **Complete this form.**
2. **Include all receipts*.**
3. **Mail to: NPS**
   P.O. Box 407
   Boys Town, NE 68010

THIS FORM TO BE COMPLETED BY EMPLOYEE				
EMPLOYEE NAME:	MEMBER ID NUMBER:	NAME OF EMPLOYER/ PLAN:		
STREET ADDRESS:	EMPLOYEE BIRTH DATE:	GROUP #:		
CITY:	STATE:	ZIP:	PHONE NUMBER: HOME: WORK: CELL:	

PATIENT NAME: (IF OTHER THAN EMPLOYEE)	GENDER:	RELATIONSHIP TO EMPLOYEE:	PATIENT BIRTH DATE:	CLAIM (S) FILED AS:
1.	☐ M ☐ F	_____	____/____/____	☐ PRIMARY INS
2.	☐ M ☐ F	_____	____/____/____	☐ SECONDARY INS
3.	☐ M ☐ F	_____	____/____/____	☐ MEDICARE

I certify that the information on this claim form is correct and authorize release of all information to NPS. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan, i.e. workman's comp. I understand that drug(s) listed below is not for treatment of an on-the-job injury or covered by any other insurance plan.

Signature:_____ Date:_____

NATIONAL PHARMACEUTICAL SERVICES HELP DESK 800-546-5677
OPEN 24 HOURS A DAY / SEVEN DAYS A WEEK FOR YOUR CONVENIENCE

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a member of National Pharmaceutical Services, will receive the "lesser" of usual and customary "U&C" charge of this provider, or the contracted price of the product. Reimbursement may be lower than the amount submitted by your pharmacy provider. NPS network pharmacies are contracted to provide services for your employer group on a fixed reimbursement schedule and this reimbursement reflects these rates. If this reimbursement has been reduced, please see your pharmacy. They are terrific allies in building cost containment programs for our employer groups.

INSTRUCTIONS

*__DO NOT PRESENT CANCELLED CHECKS, CREDIT CARD OR CASH RECEIPTS.__ THEY DO NOT CONTAIN THE INFORMATION NEEDED TO PROCESS A CLAIM. INCOMPLETE INFORMATION WILL ONLY DELAY PAYMENT.

PLEASE VERIFY THAT THE RECEIPT CONTAINS THE FOLLOWING INFORMATION ABOUT THE PRESCRIPTION(S):

☐ Pharmacy Name	☐ Patient Name	☐ NDC Number of Drug
☐ NPI / NABP Number	☐ Rx Number	☐ Days Supply
☐ Pharmacy Address	☐ Date Dispensed	☐ Quantity
☐ Phone Number	☐ Name of Drug Dispensed	☐ Amount Paid

Name of Physician: _____

The NPS staff is available to assist members and pharmacies having difficulty submitting claims for any reason. **Please talk to your pharmacy about the paperless option before you decide to fill out the manual claim form(s).** Our pharmacy network is able to process your claims within a 14-day window.

.

REMINDERS!

- *Include all original receipts. NO PHOTO COPIES.
- Prescription paper claim reimbursement will be sent to *Primary Cardholder's address* on file.

Have you answered all the questions that are applicable to your claim?