



**MEDICARE SUPPLEMENT
PRESCRIPTION DRUG CLAIM FORM**
-CONFIDENTIAL-

| Section I – Patient’s Information | | | | |
|---|---|--------------------------------|---|---|
| <i>Patient’s Name (First, Middle, Last)</i> | <i>Group Number</i> | <i>Identification Number</i> | | |
| <i>Patient’s Address (Street, City, State, Zip)</i> | | <i>Patient’s Date of Birth</i> | | |
| Section II – Subscriber’s Signature | | | | |
| <p>Acknowledgement – I understand it is a crime to knowingly provide false, incomplete or misleading information to Farm Bureau Health Plans for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.</p> <p>Subscriber’s Signature: _____ Date: _____</p> | | | | |
| Section III – Mailing | | | | |
| <p>Mail completed claim form and original prescription drug receipts or pharmacy printout to:</p> <p>Farm Bureau Health Plans • P.O. Box 300 • Columbia, TN 38402-0300</p> <p><i>For questions, contact Customer Service at 1-844-874-8300.</i></p> | | | | |
| Section IV – Instructions | | | | |
| <p>To avoid delays in processing your prescription drug claims, it is important that you read and follow these instructions carefully before submitting a claim.</p> <ul style="list-style-type: none"> • Complete a separate claim form for each patient. • Complete patient information in Section I and make sure the subscriber has signed in Section II. • Securely attach the original prescription drug receipts or a pharmacy printout to this claim form. When submitting a pharmacy printout, make sure the pharmacist has signed the printout. Do not send photocopies. • Forms, prescription drug receipts and pharmacy printouts missing required information will be returned to the patient. • If the amount you paid does not match the amount shown on the prescription drug receipt or the pharmacy printout, please attach a copy of your cash register receipt showing the amount you paid. • Keep copies of completed claim forms and prescription drug receipts or pharmacy printouts for your records. • Prescription drug claims must be filed within 12 months from the date the prescription was filled. | | | | |
| <p>Prescription drug receipts and pharmacy printouts must contain the following information:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> • Patient’s name • Name, address and NABP or NPI of pharmacy • Name of prescribing physician • Name of drug, strength, and dosage form • NDC (National Drug Code) </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> • Quantity and days’ supply • Rx number • Date prescription filled • Amount patient paid </td> </tr> </table> | | | <ul style="list-style-type: none"> • Patient’s name • Name, address and NABP or NPI of pharmacy • Name of prescribing physician • Name of drug, strength, and dosage form • NDC (National Drug Code) | <ul style="list-style-type: none"> • Quantity and days’ supply • Rx number • Date prescription filled • Amount patient paid |
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