Washington State Rx Services
P.O. Box 40168
Portland, OR 97240-0168

Uniform Medical Plan

Prescription Drug Claim Form Instructions

Alert! Please read the following instructions carefully before completing this form. Claim forms with missing information cannot be processed and will be returned to the sender.

Part 1: Member information

1. Complete all information in Part 1. The member ID number is located on your health plan ID card.
2. A claim should be submitted to Moda Health within 90 days of the date the expense was incurred. Under no circumstances will claims submitted later than one year from that date be considered valid, except in the case of legal incapacity.

Payment and related correspondence will be sent to the primary subscriber unless you have made arrangements with Moda Health to send to an alternate address. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.

Part 2: Pharmacy information (to be completed by the pharmacy)

1. If required information is not available on the prescription receipt, ask your pharmacy representative to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records.
3. Send the completed form and receipt(s) to: Washington State Rx Services ATTN: Rx Claims Department
   P.O. Box 40168
   Portland, OR 97240-0168
   Fax: 800-207-8235

Part 3: Receipt information

Please note that a <u>prescription receipt</u> is separate from your pharmacy <u>cash register receipt.</u>
Submit detailed prescription receipts or labels that contain the requested information (shown below), or have your pharmacy representative complete Part 2 and Part 3. If you do not submit a detailed prescription receipt for your prescription(s), a pharmacist signature is required.

1. Include a copy of your prescription receipt(s) along with your claim form.
   Note: Please do not staple receipts or other documentation to the claim form.
2. If you have more than one claim, submit a separate Part 3 for each medication or use the multiple prescription form on page 3.
3. Compounded drugs require additional information submitted on the Compound Claim Form (page 5). The pharmacy that filled your prescription may complete this form, or supply the information to you.
4. Receipts for medication purchased outside the U.S. must be translated into English and include conversion of currency into U.S. dollars. You also must include the required prescription and pharmacy information as indicated below.

PRESCRIPTION AND PHARMACY INFORMATION

Prescription receipt/label example: Please use this example for help locating the required information. Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 (509) 555-1234 123 Any Street * **Store NPI: 1234567890** Home Town, US 12345-6789 RX 1234567 **(3)Date Filled: 1/1/2009** **(1)DOE, JANE** **(2)DOB: 01/01/1900** 456 Home Road (509) 555-5678 Home Town, US 12345 **(7)Amoxicillin 500 mg capsules (**Teva) DAW: 0 **(6) 00000-1111-22 (4)QTY: 45 (5)Days Supply: 30** **(8)U&C: 200.00 (9)COPAY: 20.00**	1. Patient name* 2. Patient date of birth* 3. Date filled* 4. Quantity* 5. Day supply* 6. National drug code (NDC)* 7. Medication name and strength* 8. Usual and customary price (U&C)/RX price* 9. Copay* 10. Pharmacy NPI or NABP number* ***REQUIRED INFORMATION—CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED**.*

Prescription Drug Claim Form

PART 1 ***Indicates required information**

Member ID number*	Group number: **10008217**	
Group/employer name: **Uniform Medical Plan**	Primary subscriber name*	Subscriber date of birth: (mm/dd/yyyy)* / /
Member name: (first, middle, last)*	Date of birth: (mm/dd/yyyy)* / /	Relationship to primary subscriber Self ☐ Spouse ☐ Dependent ☐ Domestic partner ☐
Address: (Street, City, State, ZIP code)		
Does this member have prescription coverage under any other group health plan? ☐ Yes ☐ No If yes, provide the name of the health plan company and other employer _____		
I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.		
Member signature*	Telephone number ( )	Date

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Indicate reasons for filing a claim(s)*:

- ☐ Coordination of benefits other than Medicare—claims must be submitted with pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary health plan payment)
- ☐ Medicare is primary prescription coverage
- ☐ Discount card was used
- ☐ Health plan, health coverage information or health plan ID card was not available at the time of purchase
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency—please explain _____
- ☐ Worker's compensation
- ☐ Prescription purchased outside the U.S. Please see claim instructions on previous page.
- ☐ Other _____

Submission of claims does not guarantee reimbursement.

Alert! Non-duplication of benefits ensure that, in total, dependents with dual coverage receive benefits up to what they would have received if Uniform Medical Plan was their only source of coverage (but not in excess of that amount). Non-duplication of benefits does not apply for individuals with Medicare as the primary plan.

PART 2

Affix pharmacy label here or enter the required information:

Pharmacy name*			Pharmacy telephone number	
Street address			NPI*or NABP number	
City	State	Zip	Pharmacy representative signature*	Date*

PART 3

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

RX number	Date filled*	☐New ☐Refill (check one)	Quantity*	Day supply*	National drug code (11-digit)*
	/ /				

Medication name and strength*	Physician name and NPI number Name: _____ NPI: _____	RX price* $	Vaccine admin fee $	Copay* $

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P.O. Box 40168
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Prescription Drug Claim Form

For compounded prescriptions only

A completed Part 1 of the Prescription Drug Claim Form and pharmacy receipts* must accompany this compounded prescription form.

For Pharmacy use only

- **Enter the NDC number of all ingredients used.**
- **Indicate the drug ingredient(s) and quantity.**
- **Indicate the metric quantity dispensed in number of tablets, grams, or mls for liquids, creams, ointments, and injectables.**
- **Indicate the amount paid for the prescriptions by the patient.**
- **All plan provisions apply to compounded medications.**

COMPOUNDED PRESCRIPTION CHART			
NDC #	**Drug ingredient**	**Quantity**	**Charge**
Note: If purchased in a foreign country, the currency must be converted into U.S. dollars.		**Total**	**$**

Affix pharmacy label here or enter the required information:

Pharmacy name*			Pharmacy telephone number	
Street address			NPI*	
City	State	ZIP	Pharmacy representative signature*	Date*

Important: *The original Pharmacy prescription label/receipt (including the required drug information) must accompany this claim form. Please do not highlight receipts or items on this form as this will not show on scanned images and may cause a delay in the processing of your claim. Pharmacy receipts will not be returned, it is recommended that you make copies for your own records.*

Send the completed form and receipt(s) to:

Washington State Rx Services
Attn: Rx Claims Department
P.O. Box 40168
Portland, OR 97240-0168
Fax: 800-207-8235

Washington State Rx Services is administered by moda HEALTH

Washington State Rx Services nondiscrimination notice

Washington State Rx Services (WSRxS) complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

WSRxS provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, WSRxS also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

WSRxS Customer Service,
1-888-361-1611 (TDD/TTY 711)

If you believe that WSRxS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Washington State Rx Services
Attention: Appeal Unit
PO Box 40168
Portland, OR 97240-0168
Fax: 1-866-923-0412

If you need assistance filing a grievance, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone to:

U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

WSRxS efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

注意：如果您說中文，可得到免費語言幫助服務。請致電 1-877-605-3229（聾啞人專用：711）

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hổ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY: 711)

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TTY、テレタイプライターをご利用の方は711）までお電話ください。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយ៖ ត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនសម្រាកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.