HIP
HEALTH PLAN OF NEW YORK

PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

A. SUBSCRIBER INFORMATION

FOR OFFICE USE ONLY

Claim # _____

ID# _____ **Contract #** _____

Subscriber's Name _____
Last First MI

Street Address _____

City _____ State _____ Zip _____

SUBSCRIBER'S SIGNATURE: _____

B. PATIENT INFORMATION

Patient's Name _____
Last First MI

Date of Birth ___/___/___ (month / day / year) Male ____ Female ____ **Patient's ID #** _____

Patient's relationship to insured: Self ____ Spouse ____ Dependent ____

I certify that all Subscriber and Patient Information is correct and the medication has been dispensed. I authorize release of any information relating to this claim to HIP and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.

PATIENT'S SIGNATURE: _____

C. PHARMACY INFORMATION

NABP# _____ Tel # _____ (area code)

Pharmacy Name _____

Pharmacy Address _____

City _____ State _____ Zip _____

I certify that the prescription(s) listed below were lawfully dispensed for the above-named patient, information provided is correct and all supporting document is available for audit.

PHARMACIST'S SIGNATURE: _____

D1. PRESCRIPTION INFORMATION

Date Dispensed ___/___/___ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.

D2. PRESCRIPTION INFORMATION

Date Dispensed ___/___/___ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.

D3. PRESCRIPTION INFORMATION

Date Dispensed ___/___/___ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.

D4. PRESCRIPTION INFORMATION

Date Dispensed ___/___/___ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.