OptimaHealth

4417 Corporation Lane Virginia Beach VA 23462
Pharmacy Authorization Department

PRESCRIPTION DRUG CLAIM FORM

Cardholder's Name (last, first, MI)	Date of Birth	Gender M F	Cardholder ID Number

If this is a new address please check _____

Address Street _____

City/State _____ ZipCode _____ Daytime Telephone ( ) _____

Employer	Insurance Carrier	Group Number

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained in this claim to Sentara Health Management and my Plan Sponsor.

Cardholder's Signature _____ Date _____

Patient Information (please list information for each patient submitting claims)

	Patient's Name	Relationship to Cardholder? (circle) self, spouse, dependant	Gender (circle) M F	Date of Birth	How many prescriptions attached?
1					

Pharmacy Name and Address:	Physician Name (name of prescribing Doctor) and DEA#:

	Patient's Name	Relationship to Cardholder? (circle) self, spouse, dependant	Gender (circle) M F	Date of Birth	How many prescriptions attached?
2					

Pharmacy Name and Address:	Physician Name (name of prescribing Doctor) and DEA#:

	Patient's Name	Relationship to Cardholder? (circle) self, spouse, dependant	Gender (circle) M F	Date of Birth	How many prescriptions attached?
3					

Pharmacy Name and Address:	Physician Name (name of prescribing Doctor) and DEA#:

Is claim for Diabetic Supply? ☐ yes ☐ no if Yes, Patient's name

Type of supply (lancets, syringe, etc.) Quantity Days Supply

Does the patient reside in an assisted living facility? ☐ yes ☐ no Is this claim for allergy serum? ☐ yes ☐ no

Does the patient have primary prescription drug coverage through another insurance carrier? Yes no

Did the patient submit this claim to the carrier? ☐ yes ☐ no *If yes, please attach an explanation of benefits from your primary carrier.*

Prescription Information

→ **IMPORTANT** ← **All prescription claims must have prescriptions receipts/labels which include:**

Pharmacy Name/Address *Date Filled *Drug Name, Strength and NDC *RX Number *Quantity *Days Supply *Price *Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

☒ Please tape receipts to separate piece of paper

☒ Patient history print outs from the pharmacy are also acceptable but MUST be signed by the Pharmacist.

☒ CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.
(With the exception of diabetic supplies)

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES: