INTEGRATED PRESCRIPTION MANAGEMENT

Prescription Drug Claim Form

IPM
Attn: Claims Processing
7550 N. Palm Ave., Suite 201
Fresno, CA 93711

MEMBER INFORMATION:	
Member ID	Group Number
Name	Birth Date
Address	Phone
Employer	Employer Address
Signature	Date

PATIENT INFORMATION:

Relationship to Member:

☐ Self ☐ Spouse ☐ Dependent ☐ Other: ___________________________

Is patient covered by any other medical benefit plan, group policy plan, Medicare, or other plans?

☐ Yes ☐ No

If Yes, give the name of the person carrying coverage: _______________________________________

If Yes, name of the alternate coverage (group name, employer, association, etc): ________________

RX INFORMATION:

Attach detailed prescription receipts or ask you pharmacist to complete this information. We can not process your claim without this information.

1) Date Filled	RX Number	☐ New ☐ Refill	Quantity	Days Supply	National Drug Code (11 Digit)	
Medication (Name, Strength, Dosage Form)			Prescriber Name: DEA #:		DAW Code ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	RX Price (Including Tax)
2) Date Filled	RX Number	☐ New ☐ Refill	Quantity	Days Supply	National Drug Code (11 Digit)	
Medication (Name, Strength, Dosage Form)			Prescriber Name: DEA #:		DAW Code ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	RX Price (Including Tax)

PHARMACY INFORMATION:

Pharmacy Name	Pharmacy Phone	City/State	Pharmacy NABP #