PHARMACY REIMBURSEMENT CLAIM FORM

SUPPORT:
1.954.331.6530, OPTION 4

Forward Form and Receipts to:
JIPA Network/Claims
PO Box 2788
Kennesaw, GA 30156-9114 USA
fax: 1.770.810.3789
email: claims@jipanetwork.com

(Please Print)

Group/Plan Name or Number:		Insured's ID Number:	
PART 1 MUST BE COMPLETED BY INSURED			
Insured's Last Name: First: Middle:	Patient's Birth Date: mm/dd/yyyy	Patient's ID Number:	
Patient's Last Name: First: Middle:	Patient's Gender: ❑ M ❑ F	Patient's Relationship to Insured:	
Street Address:	Home Phone #: ( ) Email Address:	Cell Phone #: ( )	
City/Town:	Parish/State:	ZIP/Postal Code:	

Please attach detailed prescription receipts or ask the pharmacist for a pharmacy statement.
We cannot process your claims without this information.

Complete this entire form and be sure to sign it.

Forms without required information cannot be processed.

- Use a separate form for each Pharmacy
- Use a separate form for each Patient

You must submit claims within six months of the date of purchase or as required by your Plan.

Submission Requirements. You MUST include all original Pharmacy receipts in order for your claim to process. "Cash Register" receipts **will not** be accepted. The minimum information that is required on the pharmacy receipt includes:

● Patient Name ● Prescription Number ● Name of Drug and Strength
● Medicine NDC Number ● Date Filled ● Doctor Name or ID Number
● Metric Quantity and Days Supply ● Compound Drug Information
● Total Charge (with Currency) ● Total Paid (with Currency)
● Pharmacy Name, Address and Phone Number

ACKNOWLEDGMENT

I certify that the attached medications were received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X ______________________________ X ______________________________
Signature Date

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.

COORDINATION OF BENEFITS

Is the Insured or Patient Covered under any Other Plan? ❑ Yes ❑ No

If Yes, and You are submitting an Explanation of Benefits (EOB) from another Health Plan: If you have not already done so, submit the claim to the Primary Plan. Once the EOB is received, complete this form, tape the original prescription receipt(s) to the form and attach the EOB from the Primary Plan, which clearly indicates the cost of the prescription and what was paid by the Primary Plan.

or You are submitting a copay receipt: If your Primary Plan is one in which co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Complete this form and attach the prescription receipt(s) that shows the co-payment or coinsurance amount paid at the pharmacy.

Name and Address of Pharmacy:

Pharmacy Phone: ( ) ______________________.

Email: ______________________________

Company TIN: ______________________________