

**Instructions for completing the Prescription Drug Claim Form:**

Please complete **all** sections of the claim form below.

- Only one patient can be submitted per claim form.
- Pharmacy receipts must be included with your submitted claim form. Pharmacy receipts are attached to the prescription bag at the time of purchase and are not cash register receipts.
- The pharmacy receipts must show the following prescription information for each expense:
  - Pharmacy Name and Address      – Patient Name
  - Prescription Number              – Fill Date
  - Drug Name, Strength, and NDC   – Quantity and Days' Supply
  - Prescriber Name                    – Drug Cost and Amount Paid Out-of-Pocket
- Please mail or fax the completed form and accompanying receipts to:  
Magellan Health Services  
Attention: Claims Department  
P. O. Box 1599  
Maryland Heights, MO 63043  
  
**Fax:** 1-800-424-7578  
**Phone:** 1-800-424-7549

**Please Note:** Remember you must include copies of all pharmacy receipts for your claim to be processed for reimbursement. Pharmacy receipts are attached to the prescription bag at the time of purchase and are not cash register receipts.

1. Patient Name (First, Middle, Last) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_

2. Patient Yale Health ID No. (as shown on IDcard) \_\_\_\_\_

3. Patient's Birth Date \_\_\_\_\_

4. Is the patient eligible for any other Prescription Drug Coverage?  
 No     Yes    If yes, complete the following:

Insurance Company Name \_\_\_\_\_  
Address (Street, City, State, Zip Code) \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's ID Number \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_  
Effective Date(s) \_\_\_\_\_

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Magellan Rx Management, its agents, or representatives.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_