MEDTRAK Pharmacy Services

MEDTRAK MEMBER CLAIM FORM

Instructions for completing this form are on the reverse side.
Incomplete or illegible information will result in form being returned or payment delays.

MEMBER INFORMATION

(The member is the person for whom the prescription was written)

Member Name: _____ Date of Birth _____

MedTrak Identification Number: _____

The member is: ____ Cardholder _____ Spouse _____ Dependent

Member mailing address: _____

_____

Daytime phone number _____

PRESCRIPTION INFORMATION

Total number of individual prescription claims being submitted for reimbursement _____
(please attach receipts/printouts to the back of this form)

Were any of these prescriptions submitted to and paid for by another insurance plan? Yes No

Member must submit Pharmacy receipt(s) or a Pharmacy printout for each claim that includes: name, address, and phone number of pharmacy; date prescription was filled; prescription number; NDC number; drug name and strength; quantity; days supply; dollar amount member paid to the pharmacy.

NOTES:

By signing below, I certify the above information is correct. Must be signed by the person for whom the prescriptions were written. Cardholder should sign only if member is a legal dependent of the cardholder.

Member Signature _____ Date _____

Mail to: **MedTrak Services**
7101 College Blvd., Ste. 1000
Overland Park, KS 66210

Fax to: **MedTrak Services**
Attn: Keyed Claims
913-262-8939

If reimbursement is due, member will receive check in approximately eight weeks.
The reimbursement check will be mailed to the member unless the member is a legal dependant of the cardholder. In these cases the cardholder will receive the check. Put special handling instructions in "notes" box above.
The amount of reimbursement received may be less than member paid to the pharmacy
If you need assistance completing form or have questions regarding this reimbursement process, contact
MedTrak Customer Service at 1-800-771-4648.

Instructions for completing MedTrak Member Claim Form

All information must be provided in order to accurately process your claim(s).
Incomplete or illegible information will result in form being returned or payment delays.

MEMBER INFORMATION

* Member Name	Enter the person for whom the prescription was written. This is either the cardholder, the spouse of the cardholder, or a dependent of the cardholder.
* Date of Birth	Enter the birth date of person for whom the prescription was written.
* MedTrak ID Number	Enter the member Identification Number assigned to you by MedTrak.
* The member is:	Check only one: cardholder, spouse, or dependent.
* Address	Enter permanent mailing address – this is the address where the reimbursement check will be mailed unless other instructions are given in the "notes" box.
* Phone number	Enter a daytime phone number in case we need to contact member to resolve questions. regarding the claim. If member is a minor, include name of cardholder or spouse.

PRESCRIPTION INFORMATION

- Please indicate the total number of individual prescriptions you are submitting for reimbursement. This number should be the same number of attached receipts and/or line items on a printout.
- Most Pharmacies supply a receipt for each individual prescription which includes the required information. If you have lost a receipt, or have multiple claims, the Pharmacy can supply you with a printout of prescriptions for a given time period. Either the receipt or the printout will be sufficient if it provides the following information:
  1. the name, address, and phone number of the pharmacy.
  2. the date the prescription was filled.
  3. the number assigned to the prescription by the Pharmacy.
  4. the Nation Drug Code (NDC), which identifies the drug product dispensed.
  5. the name and strength of the drug dispensed.
  6. the quantity of the product dispensed.
  7. the number of days the dispensed quantity is expected to last.
  8. the dollar amount the member paid the Pharmacy for the prescription.
- Cash register receipts do NOT have the information required to process a claim.
- Indicate if any of these claims have already been submitted to and paid for by a prescription plan that is different than the MedTrak plan indicated by the Identification Number in the Member Information Section.

NOTES

This space is provided for the member to be able to provide MedTrak with any additional information which might be helpful or pertinent to processing the submitted claims.

MEMBER SIGNATURE AND DATE

The completed form must be signed by the member (person who received the prescriptions) unless the member is a minor or is incapable of signing form. In cases where the member is a legal dependant of the cardholder, the cardholder should sign the form. By signing the form, the member is certifying the information submitted is correct.

GENERAL INFORMATION

Being able to submit paper claims to MedTrak for manual "keying" and potential reimbursement is part of your prescription benefit package. However, it is important to understand it is to your advantage to have the pharmacy submit the claims on-line to MedTrak whenever possible.

- **The amount of reimbursement received may be less than the member paid at the pharmacy based on a number of variables including plan design, deductibles, co-payments, and discounted price of drug. In addition, reimbursement takes approximately eight weeks from the time the claim is submitted to the time the member receives the check.**
- When the claim is submitted "on-line" to the pharmacy, the member is responsible only for deductibles and co-payments determined by the plan design.

In situations where the pharmacy can not or will not submit on-line to MedTrak, we are happy to process those claims manually based on the guidelines of your plan design.

If you need assistance completing form or have questions regarding this reimbursement process, contact
MedTrak Customer Service 1-800-771-4648.