THE EMPIRE PLAN
New York State Health Insurance Program

ENROLLEE CLAIM SUBMITTAL FORM

Part 1
Enrollee Information

Part 1 must be fully completed to ensure proper reimbursement of your medicine claim.

Please type or print clearly.

Enrollee ID No.

Enrollee Name | Address

City | State | ZIP | Phone ( )

Patient Information — Use a separate claim form for each family member

Patient Name | Date of Birth

Patient: ❍ Male ❍ Female Relationship: ❍ Self ❍ Spouse/Domestic Partner ❍ Child ❍ Other ________

Are any of these medicines being taken for an on-the-job injury? ❍ Yes ❍ No

Is the medicine covered under any other group insurance? ❍ Yes ❍ No

If yes, is other coverage: ❍ Primary ❍ Secondary If other coverage is Primary, include the explanation of benefits (EOB) or pharmacy receipts with this form.

Name of Insurer | Policy # | ID # | Phone ( )

Important! A signature is REQUIRED in both A and B.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A x

Signature of Enrollee or Legal Representative **Date**

Release of Information: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury. I authorize release of all information pertaining to this claim to Caremark, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

B x

Signature of Enrollee or Legal Representative **Date**

Part 2
Important!

Please remember to include all original pharmacy receipts.

If you are including all original receipts with the following information, STOP HERE and submit the claim. It is not necessary to complete Part 3. **NOTE:** Do not staple or tape receipts or attachments to this form.

- Enrollee Name
- Date Purchased
- Medicine Name
- Pharmacy Name and Address or NABP Number
- Total Charge
- Metric Quantity, Days Supply
- Prescription Number
- Medicine Strength/or NDC Number

Part 3
Pharmacy Information

Pharmacist to complete this section ONLY if original pharmacy receipts are not included.

- To ensure that the enrollee receives accurate and timely reimbursement for medicine purchases, please assist in completing the information below.
- **If compound prescription, please enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescriptions section on the reverse side.**

Pharmacy Name | Pharmacy NABP No.

Pharmacy Address | City

State | ZIP | Phone ( )

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the enrollee.

x

Signature of Pharmacist or Representative **Date**
(Required only if original pharmacy receipts are not included)

Rx 1

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
NDC #	Medicine Name and Strength	Metric Quantity	Days Supply	Total Charges

Rx 2

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
NDC #	Medicine Name and Strength	Metric Quantity	Days Supply	Total Charges

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INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each enrollee/dependent
- Each pharmacy from which you purchase prescription medicines

CLAIM SUBMISSION

When submitting a claim, the following information must be included:

- Pharmacy Name and Address or NABP Number
- Prescription Number
- Date of Purchase
- Medicine Name
- Medicine Strength/or NDC Number
- Metric Quantity/Days Supply
- Total Charge
- Original Pharmacy Receipts
- Pharmacist's Signature (only if original pharmacy receipts are not included)

DO NOT submit canceled checks, cash register slips or pharmacy summary report. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

HOW TO COMPLETE THIS FORM

Enrollee Information

Complete all enrollee information in Part 1 on reverse side.

- The enrollee number can be found on your Empire Plan benefit card.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Caremark. No documents will be returned.

PHARMACY INFORMATION

Pharmacist to complete Part 3 of the form for compounds even if there was an original receipt submitted

- Indicate pharmacy name, NABP number, address and phone number.
- Include prescription number(s), medicine name(s), strength(s) and date filled.
- Indicate prescriber's DEA number and whether the prescription is new, refill, DAW or compound.
- Include NDC number(s) for the medicine(s) dispensed.
- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend medicine used.
- Indicate the medicine ingredient(s) and quantity.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables.
- Indicate the "days supply" (the number of days the medicine will last).
- Indicate the amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call Caremark toll-free at 1-877-7-NYSHIP (1-877-769-7447).

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC #	Prescription Ingredient	Quantity	Charge

MAIL THIS FORM TO:

The Empire Plan Prescription Drug Program / P.O. Box 52071 / Phoenix, AZ 85072-2071

If you have questions, please contact: 1-877-7-NYSHIP toll-free (1-877-769-7447), then select the Empire Plan Prescription Drug Program. **If you need additional forms:** Go to www.cs.state.ny.us, select Benefit Programs, then select NYSHIP online and if prompted, choose your group.