

# Pharmacy Claim Form

P.O. Box 930, Frederick, MD 21705

Please include pharmacy receipt along with sales receipt for proper processing of your claim. Enrollee will only be reimbursed if acceptable proof of payment is submitted with claim. If pharmacy receipt is not included, please contact your pharmacist for the pharmacy and drug information with signature.

Please circle your plan name:

OPTIMUM CHOICE, INC.  
A MAMSI/UnitedHealthcare Company

M.D. IPA™  
A MAMSI/UnitedHealthcare Company

MAMSI Life and Health Insurance Company  
A UnitedHealthcare Company

## Enrollee Information

|               |     |   |  |                        |  |
|---------------|-----|---|--|------------------------|--|
| Member Number |     | Group Number                            |  | Social Security Number |  |
| Name (Last)   |     | (First)                                 |  | (M.I.)                 |  |
| Address       |     |   |  |                        |  |
| Date of Birth | Sex | Relationship to Subscriber (circle one) |  | Telephone Number       |  |
|               | M/F | Self / Spouse / Dependent Child         |  |                        |  |

## Pharmacy Information

|                |  |                   |  |                  |  |
|----------------|--|-------------------|--|------------------|--|
| Pharmacy Name  |  | Pharmacy NABP No. |  | Telephone Number |  |
| Street Address |  | City              |  | State            |  |
|                |  |                   |  | ZIP              |  |

## Drug Information

| Rx Number | Drug Name | Drug NDC Number | Date of Service | Quantity | Day Supply | DAW |
|-----------|-----------|-----------------|-----------------|----------|------------|-----|
|           |           |                 |                 |          |            |     |
|           |           |                 |                 |          |            |     |
|           |           |                 |                 |          |            |     |
|           |           |                 |                 |          |            |     |
|           |           |                 |                 |          |            |     |

Is this a compounded medication?  Yes  No If Yes, please fill out below.

| Rx Number | Drug Name | Date of Service | Quantity | Day Supply |
|-----------|-----------|-----------------|----------|------------|
|           |           |                 |          |            |
|           |           |                 |          |            |
|           |           |                 |          |            |
|           |           |                 |          |            |

| Ingredients (Drug Name) | NDC No. (if applicable) | Quantity Used | DAW |
|-------------------------|-------------------------|---------------|-----|
|                         |                         |               |     |
|                         |                         |               |     |
|                         |                         |               |     |

I hereby certify that the charge(s) shown for the medication(s) prescribed is (are) correct, and I agree to provide MAMSI Health Plans reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the health plan enrollee.

Pharmacist Signature \_\_\_\_\_

Date \_\_\_\_\_

I hereby certify that the information I have given is accurate to the best of my knowledge, and that the medication received was not for an on-the-job injury. This information may also be used for other reporting and analysis purposes without identification of me or my family members. I recognize that reimbursement will be paid directly to me. I further recognize that reimbursement may be based on the maximum allowable cost of the drug, minus my copayment.

Enrollee Signature \_\_\_\_\_

Date \_\_\_\_\_

Subscriber Signature \_\_\_\_\_

Date \_\_\_\_\_