Prescription Paper Claim Form

INTERCEPT rx SOLUTIONS

Please complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. Submit this form with the original prescription receipt(s). **Cash Register, cancelled checks, and credit card receipts are NOT acceptable as proof of purchase.** This will only delay payment as they do not contain the necessary information needed to process a claim. Reimbursement is not guaranteed. Claims will be subject to limitations and other provision of the plan benefit.

Patient Information

(one form per patient)

Cardholder Name:	Cardholder DOB:	Cardholder ID #	Cardholder Gender: ☐ Male ☐ Female
Mailing Address:	City:	State: Zip Code:	Primary Phone #: Secondary Phone #:
Member Name *(if other than cardholder)*	Member DOB:	Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other	Member Gender: ☐ Male ☐ Female
Health Plan (Insurance) Name:	Prescribing Physician's Name:	Physician's Phone #:	Drug Name:

Reason for Request

(at least one must be checked)

☐ Out of Area emergency medication
☐ Non-emergency medication/vacation request
☐ Identification card not available or member not found pharmacy system
☐ Compound
☐ Coordination of Benefit (From Primary Insurance)
☐ Other_____ in the

I certify that the information on this claim form is correct and authorize release of all information to Intercept Pharmacy Solutions. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan, i.e. workman's comp. I understand that drug(s) listed below is not for treatment of an on-the-job injury or covered by any other insurance plan.

Please remit payment and/or explanation of benefits to: (check one)

☐ Cardholder (Primary Subscriber) ☐ Dependent

Signature: **Date:**

Intercept Pharmacy Solution: 888-960-0668
Open Monday – Friday: 5:00 AM/PST to 9:00 PM/PST
Saturday: 7:00 AM to 7:00 PM/PST, Sunday: 7:30 AM/PST to 4:00 PM/PST for your convenience

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a member of Intercept Pharmacy Solutions, Inc. will receive the "lesser" of usual and customary "U&C" charge of this provider, or the contracted price of the product. Reimbursement may be lower than the amount submitted by your pharmacy provider. Intercept Pharmacy Solutions network pharmacies are contracted to provide services for your pharmacy benefit plan on a fixed reimbursement schedule and this reimbursement reflects these rates. If this reimbursement has been reduced, please see your pharmacy. They are terrific allies in building cost containment programs for our health plan.

Please verify that the Prescription receipt contains the following information about the prescription:

☐ Pharmacy Name	☐ Physician Name	☐ Name of Drug Dispensed	☐ Days Supply
☐ Pharmacy Address	☐ Patient Name	☐ NDC Number of the drug	☐ Quantity Dispensed

☐ Pharmacy Phone Number	☐ Date of Service	☐ Prescription Number	☐ Amount Paid

Please mail label receipts and this complete form to:
Intercept Pharmacy Solutions, Inc.
10400 Overland Road
Box #353
Boise, ID 83709
The Intercept Pharmacy Solutions staff is available to assist members and pharmacies having difficulty submitting claims for any reason.
Our pharmacy network is able to process your claims within a day window.