



Prescription Drug Claim Form Direct member Reimbursement

Use this form for prescriptions that were purchased without using your ID card.
Claim submission is not a guarantee of payment. Reimbursement is subject to plan pharmacy benefits.

Cardholder Name:	Cardholder #:		
Cardholder Address:	City:	State:	Zip:
Group # (RxGrp):	Group Name (RxPCN):		
Patient Date Of Birth:	Patient's Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Send check to:			
Does Patient have other drug coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, and other insurance <i>is</i> Medicare, attach a copy of the Medicare Explanation of Benefits (MEOB). If yes, and other insurance <i>is not</i> Medicare, include denial notification from the primary insurance carrier or pharmacy printout.			

PRESCRIPTION/ OTHER INSURANCE INFORMATION:

THIS SECTION MUST BE COMPLETED BY YOU OR YOUR DISPENSING PHARMACIST.
PRESCRIPTION RECEIPTS OR PHARMACY PRINTOUTS MUST BE ATTACHED; SALES RECEIPTS WITHOUT PHARMACY
DETAIL WILL NOT BE ACCEPTED. RECEIPTS CANNOT BE RETURNED. PLEASE KEEP A COPY.

# 1 Pharmacy Name _____	Address _____		
Rx Number _____	Drug Name & Strength _____	NDC # _____	
Original Date of Rx _____	Date Filled _____	Quantity _____	Days Supply _____
Physician Name _____	Physician NPI # (if available) _____		
Other Insurance Company Name _____	Other Insurance Phone Number _____		
Original Cost of Rx \$ _____	Amount Primary Insurance Paid on Rx \$ _____	Patient Paid Amount \$ _____	Vaccine Admin Fee \$ _____

# 2 Pharmacy Name _____	Address _____		
Rx Number _____	Drug Name & Strength _____	NDC# _____	
Original Date of Rx _____	Date Filled _____	Quantity _____	Days Supply _____
Physician Name _____	Physician NPI # (if available) _____		
Other Insurance Company Name _____	Other Insurance Phone # _____		
Original Cost of Rx \$ _____	Amount Primary Insurance Paid on Rx \$ _____	Patient Paid Amount \$ _____	Vaccine Admin Fee \$ _____

I CERTIFY THE ABOVE INFORMATION IS CORRECT, AND THE PRESCRIPTIONS LISTED ABOVE ARE FOR ME OR FOR ELIGIBLE MEMBERS OF MY FAMILY WHO HAVE RECEIVED THE MEDICATION DESCRIBED ABOVE. I AUTHORIZE RELEASE OF ALL INFORMATION CONTAINED ON THIS CLAIM TO COLORADO ACCESS.

SIGNATURE: _____ DATE SIGNED: _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

MAIL TO:
COLORADO ACCESS
GRIEVANCES AND CLINICAL APPEALS
PO BOX 17950
DENVER, CO 80217-0950
Or FAX: 303-755-4148

Please include all itemized receipts or your request may be delayed.