Geisinger

Pharmacy Reimbursement Claim Form

Step 1 Fill out form completely, providing information for up to two prescriptions. Ask your pharmacist to provide the information requested on this form that may not be familiar to subscriber.

Step 2 Attach prescription label and receipt of payment for prescription (s). This can be in the form of a prescription information slip.

Step 3	**Member Information**	
Name Last	First	
Insurance ID Number	Date of Birth:	
Street Address		
City	State	Zip
Telephone ( )		

☐ Check if new address

Have the prescription (s) been submitted to an insurance company other than Geisinger Health Plan.
(Please circle) Yes No

Step 4	**Prescription Information**
Pharmacy:	Pharmacy NPI:
Pharmacy Address:	State: Zip:
Drug/Product Name:	**Rx#**
Date Prescription filled:	NOC Dispensed:
Day Supply: Quantity Disp:	Amount Paid:
Prescriber:	Prescriber NPI:

Prescription Information	
Pharmacy:	Pharmacy NPI:
Pharmacy Address:	State: Zip:
Drug/Product Name:	**Rx#**
Date Prescription filled:	NOC Dispensed:
Day Supply: Quantity Disp:	Amount Paid:
Prescriber:	Prescriber NPI:

Signature: _____ Date _____

I certify that the information is correct and that the prescription listed above are for myself or member of my family who are eligible. I have received the medication described above and authorization release of all information contained on this claim to my plan sponsor

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND FILL OUT THE FRONT SIDE OF THIS FORM.

A SEPARATE FORM MUST BE COMPLETED FOR EACH MEMBER

MEMBER SUPPLIED INFORMATION:

I. Please print the requested information.
2. Print member's insurance id number (found on insurance card)
3. Print member's date of birth in the mm/dd/yyyy format.
4. Print member's name, first, last, middle initial or as it appears on the card.
5. Check box if this is a new address.
6. Indicate if you are seeking other reimbursement for the claims you are submitting
7. Print the pharmacy name.
8. Print the pharmacy address.
9. **ATTACH a copy of receipt, prescription package insert and leaflet.**

PHARMACIST SUPPLIED INFORMATION:

I. Print the pharmacy's name (store number if applicable).
2. Enter the pharmacy's NPI number.
3. Print the pharmacy's address.
4. Enter the date of service in the mm/dd/yyyy format.
5. Print the drug name and strength
6. Enter the metric quantity dispensed.
7. Enter the I 0-digit NOC of the drug dispensed.
8. Enter the amount paid by the member.
9. Print the name of the prescriber.
10. Enter the prescriber's NPI number.

IMPORTANT:

I. The member must sign and date each form to be eligible for reimbursement.
2. Completion and submission of this form does not guarantee requested reimbursement.

QUESTIONS? Call Geisinger Health Plan Pharmacy Services at 1-8 00 - 988-4861 or 570-271-5673

PLEASE RETURN THIS CLAIM FORM TO: GHP PHARMACY CLAIMS DEPARTMENT
100 N ACADEMY AVE
DANVILLE, PA 17822-3240

OR FAX TO: 570-271-5610

DID YOU SIGN AND DATE THE FRONT OF THIS CLAIM FORM?

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

***Geisinger Health Plans* refers collectively to Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company.**