



APWU HEALTH PLAN

P.O. BOX 1358 GLEN BURNIE, MD 21060
PHONE: 800-222-APWU

CARRIER USE ONLY

PRESCRIPTION DRUG CLAIM FORM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. INSURED'S ID NUMBER
2. INSURED'S NAME & ADDRESS
3. PATIENT (CHECK PATIENT'S NAME: ONLY ONE PATIENT PER CLAIM FORM)
4. PATIENT'S BIRTH DATE
5. PATIENT'S SEX CIRCLE: MALE FEMALE
6. PATIENT'S APWU GROUP NUMBER AS INDICATED ON YOUR PRESCRIPTION DRUG CARD (IF NOT INCLUDED ABOVE)

7. DOES PATIENT HAVE MEDICARE? IF YES, PLEASE INDICATE EFFECTIVE DATE AND ATTACH EOMB FROM MEDICARE CARRIER.
PART "A" EFFECTIVE DATE
PART "B" EFFECTIVE DATE

8. IS PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE? YES NO
IF YES, PLEASE INDICATE NAME OF POLICY HOLDER, PLAN NAME, ADDRESS, POLICY NO. AND PHONE NO. IF NO, PLEASE SIGN AND DATE.
9. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT? YES NO
IF YES, INDICATE FILE NO.
B. AN AUTO/MOTORCYCLE ACCIDENT? YES NO
(PLEASE CIRCLE ONE)
IF YES, PLEASE ATTACH PAYMENT STATEMENT.

10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE AUTHORIZING THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
SIGNED: DATE:

CLAIMS FILING INSTRUCTIONS: Please Print

The member must complete and sign this form.
You must attach supporting receipts. Cancelled checks and balance due statements are not acceptable. Please list purchases in date order.
1. Non-prescription items and over-the-counter drugs are not covered.
2. RX, NDC (National Drug Code) and NABP (Pharmacy Identification) Numbers are required.
3. Claims must be submitted by December 31 of the year after the year you incur the expense. Failure to file within this limit will invalidate your claim.

Table with 8 columns: Date of Purchase, Rx Number, NDC Number (11 Digits), Brand or Generic Name of Drug, Days Supply, Qty., Prescribing Physician, Drug Charge

I certify the Rx drugs listed were purchased for the patient named and DO NOT include drugs that can be purchased OVER THE COUNTER with or without a doctor's prescription.

Supplier's Federal Tax ID Number Pharmacy NABP Number Pharmacist's Signature

Pharmacy Name and Address

I certify the above statement to be correct.

Date Member's Signature

WARNING: Any intentional false statement on this claim or willful misrepresentation relative thereto is a violation of the law, etc. (18 U.S.C. 1001).