# Caterpillar Prescription Drug Claim Form

Magellan Rx MANAGEMENT

Instructions for completing Prescription Drug Claim Form:

Please complete all sections of the claim form below.

- Only one patient can be submitted per claim form.
- Copies of pharmacy receipts must be included with submitted claim form. Pharmacy receipts are attached to the prescription bag at the time of purchase and are not cash register receipts.
- The pharmacy receipts must show the following prescription information for each expense:

| | | |
|---|---|---|
| - Pharmacy Name and Address | - Patient Name | - Prescriber Name |
| - Prescription Number | - Fill Date | - Drug Cost |
| - Drug Name, Strength and NDC | - Quantity and Days' Supply | - Amount Paid Out-of-Pocket |

- Please mail or fax the completed form and accompanying receipts to:

  Magellan Rx Management, LLC
  Attn: Claims Dept.
  11013 W. Broad St., Ste #500
  Glen Allen, VA 23060
  **OR Fax:** 1-800-424-7644

- If you have any questions, please call Customer Service at 1-877-228-7909.

**Please Note: This claim will not be processed until this form and accompanying receipts are submitted.**

1. Policyholder or Insured Name (First, Middle, Last) _____

   Address _____

   City _____ State _____ Zip Code _____
2. Policyholder or insured ID No. (as shown on ID Card) _____
3. Why was the insurance or drug card not used for this purchase? _____
4. Patient's Name (First, Middle, Last) _____
5. Patient's Birth Date _____
6. Does the member reside in a long-term care or assisted living facility? ☐ No ☐ Yes
7. Patient's Relationship to Policyholder:

   ☐ Self ☐ Spouse ☐ Dependent ☐ Other

8. Is the patient eligible for any other Prescription Drug Coverage? ☐ No ☐ Yes If yes, complete the following:

Does the coverage include: ☐ Major Medical ☐ Drug ☐ Other Medical

Insured's Name _____ Insured's ID Number _____

Insurance BIN and PCN (on ID Card) _____ Effective Date _____

Insurance Company Name _____

Address (Street, City, State, Zip Code) _____

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Magellan Rx Management, its agents, or representatives.

**Signature** _____ **Date** _____