BeneScript®
A division of HEALTHTRANS

SEVEN CORNERS Prescription Drug Claim Form

Important!
Always allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing. Make a copy of all documents submitted and do not staple or tape receipts or attachments to this form. No documents will be returned.

Mail to: HealthTrans
PO Box 4557
Greenwood Village, CO 80155

Subscriber Information

ID Number (claim cannot be processed without ID Number)	Group Number (claim cannot be processed without Group Number)
	R X 2 5 3 7

Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)

Address (Street, City, State, Zip)

Telephone Number	Date
( )	

Patient Information

Prescription(s) were for:

Patient Name (First, Middle, Last)	Sex	Patient Birthdate (MM/DD/YYYY)
	☐ Male ☐ Female	

Pharmacy Information

Pharmacy Name	Pharmacy NABP Number

Pharmacy Address (Street, City, State, Zip)

Pharmacy Telephone Number
( )

Prescription Information

Please attach the **prescription receipts** *to the back of this form. You can ask your* **pharmacist** *for assistance in completing the information below. We cannot process your claim without this information.*

❶ Date Filled	Rx Number	Rx (Check One)	Quantity	Days Supply	National Drug Code (11 digits)	
		☐ New ☐ Refill				
Medication Name, Strength, Dosage Form			Physician Name: ______ DEA #: ______		DAW (Check one) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Rx Price (Including tax)

❷ Date Filled	Rx Number	Rx (Check One)	Quantity	Days Supply	National Drug Code (11 digits)	
		☐ New ☐ Refill				
Medication Name, Strength, Dosage Form			Physician Name: ______ DEA #: ______		DAW (Check one) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Rx Price (Including tax)

❸ Date Filled	Rx Number	Rx (Check One)	Quantity	Days Supply	National Drug Code (11 digits)	
		☐ New ☐ Refill				
Medication Name, Strength, Dosage Form			Physician Name: ______ DEA #: ______		DAW (Check one) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Rx Price (Including tax)

❹ Date Filled	Rx Number	Rx (Check One)	Quantity	Days Supply	National Drug Code (11 digits)	
		☐ New ☐ Refill				
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Submission Requirements
You MUST include all original receipts for your claim to process. You MUST include your pharmacy receipt. Cash register receipts will only be accepted for diabetic supplies. The minimum information required is:

- Patient Name
- Date of Fill
- Total Charge
- Prescription Number
- Metric Quantity
- Pharmacy Name and Address or Pharmacy NABP Number
- Medicine NDC number
- Days Supply

Example Pharmacy Receipt:

Dispenser (Pharmacy Name & Address) → FAMILY DRUG, INC. IN FAMILY FOODS 2S501 ROUTE 59,WARRENVILE IL 605551254 (630)393-7200

RECEIPT SAVE FOR INSURANCE OR TAX RECORDS

Prescription # → Rx# 1234567

Total Charge → $ 22.76

Fill Date → Filled: 9/07/06

Patient Name → John Smith 1234 West Way Washington, DC 85001

TOPROL XL 100MG TAB

NDC # → NDC# 00186-1092-05 Dr. ANGELO MIELE

DS 15 (Days Supply) Qty #15 (Quantity) RPH LAF/SB

Mail This Completed Form To:
HealthTrans
Attn: Claims Processing
PO Box 4557
Greenwood Village, CO 80155

To avoid having to submit a paper claim form:
- Always have your card available at time of purchase.
- Always use pharmacies within your network
- Use medication from your formulary list
- If problems are encountered at the pharmacy, call the number on the back of your card

Important! A signature is REQUIRED in both A and B

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

______________________________ ________________
Signature of Plan Participant Date

Release of Information: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to HealthTrans, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

______________________________ ________________
Signature of Plan Participant Date