Pharmacy Benefit Dimensions®
An Independent Health company

Pharmacy Claim Form

This form is for members with prescription drug coverage through Pharmacy Benefit Dimensions. Use this claim form to submit prescription drug receipts to Pharmacy Benefit Dimensions for reimbursement. **A separate claim form and itemized bill must be submitted for each patient/member for services rendered.**

Please complete questions 1-4 on this claim form. Sign, date and return this form to Pharmacy Benefit Dimensions along with your itemized prescription drug receipt (not your cash register receipt) from your pharmacy. Mail to:

Pharmacy Benefit Dimensions
Attn: Pharmacy Department
511 Farber Lakes Drive
Buffalo, NY 14221

PHARMACY RECEIPTS MUST INCLUDE:

- **Pharmacy Name**
- **Name and quantity of drug dispensed**
- **Date prescription was dispensed**
- **Name of the doctor who ordered the prescription**
- **Member paid expense**

Claim(s) will be returned if the member/subscriber's signature is not present.

If you have any questions or need additional copies of this form, please call our Medicare Customer Service Center at (716) 250-4401 or toll free at 1-800-665-1502. TTY users should call 1-800-432-1100. Service hours are October 1- February 14: Monday- Sunday, 8 a.m. - 8 p.m., February 15- September 30: Monday- Friday, 8 a.m. – p.m.

1. PATIENT'S NAME (Last Name, First Name, MI)

2. PHONE NUMBER

3. PATIENT'S MEMBER ID NUMBER (11 Digits)

__ __ __ __ __ __ __ __ __ __ __

4. DATE OF BIRTH

__ __/__ __/__ __ __ __

Coordination of Benefits

If your primary insurance has already paid for the attached prescription, please complete this section.

Primary Health Plan/Insurance Company Name

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(please turn to page 2)

Primary Member/Subscriber's Name (Last Name, First Name, MI)

Primary Member/Subscriber's ID

_____

I certify that the patient for whom this claim is made is a covered person in this prescription drug program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X_____ _____

MEMBER'S NAME DATE