AMWINS | Rx®

Use this form to request reimbursement for claims that your Pharmacy didnt process under your insurance.

Your RX Benefit may also be used at non-participating pharmacies. Simply pay for the prescription, keep your receipt, and contact Amwins to file a claim for reimbursement. You have 12 months from date of service to request a reimbursement.

Cardholder Name: ______________________ Cardholder ID: ______________________

Patient Name: ______________________ Patient DOB: ______________________

Cardholder Address: ______________________ City/State: ____________ ZIP Code ________

Phone Number: ______________________

Is this a Coordination of Benefits Claim? Yes No

Internal Use Only: Episode Number:

Please include a pharmacy receipt for each medication to avoid denial and/or delays in processing your case.
A cash register receipt alone cannot be used to process your claims.

All information in the below boxes must be completed in order to avoid delay or denial of your claim.

Medication #1			Medication #2		
Pharmacy NABP: (Obtain from pharmacy)			Pharmacy NABP: (Obtain from pharmacy)		
Fill Date:			Fill Date:		
RX #:			RX #:		
National Drug Code (NDC) (11 Digits)			National Drug Code (NDC) (11 Digits)		
Medication Name:			Medication Name:		
Medication Strength:			Medication Strength:		
Physician Name:			Physician Name:		
Physician NPI: (Obtain from physician)			Physician NPI: (Obtain from physician)		
Quantity/Day Supply:			Quantity/Day Supply:		
Patient Paid:			Patient Paid:		

Please provide a brief explanation regarding why you paid out of pocket for your medication(s). (Attach a separate sheet if additional space is required)

This form can be faxed to: 866-646-1403 OR This form can be mailed to:

Amwins Rx - DMR
7835 Freedom Avenue NW
North Canton, OH 44720

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All information in the below boxes must be completed in order to avoid delay or denial of your claim.

Additional Medication			Additional Medication		
Pharmacy NABP: (Obtain from Pharmacy)			Pharmacy NABP: (Obtain from Pharmacy)		
Fill Date:			Fill Date:		
RX #:			RX #:		
National Drug Code (NDC) (11 Digits)			National Drug Code (NDC) (11 Digits)		
Medication Name:			Medication Name:		
Medication Strength:			Medication Strength:		
Physician Name:			Physician Name:		
Physician NPI: (Obtain from Physician)			Physician NPI: (Obtain from Physician)		
Quantity/Day Supply:			Quantity/Day Supply:		
Patient Paid:			Patient Paid:		

Additional Medication			Additional Medication		
Pharmacy NABP: (Obtain from Pharmacy)			Pharmacy NABP: (Obtain from Pharmacy)		
Fill Date:			Fill Date:		
RX #:			RX #:		
National Drug Code (NDC) (11 Digits)			National Drug Code (NDC) (11 Digits)		
Medication Name:			Medication Name:		
Medication Strength:			Medication Strength:		
Physician Name:			Physician Name:		
Physician NPI: (Obtain from physician)			Physician NPI: (Obtain from physician)		
Quantity/Day Supply:			Quantity/Day Supply:		
Patient Paid:			Patient Paid:		

For additional medications, attach a separate page.

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INSTRUCTIONS

A. WHEN TO USE THIS FORM

1. This claim form is to be used only when it has been necessary to purchase prescriptions because your participating pharmacy did not honor your identification card or was unable to directly submit your claim. It should also be used when it was necessary to have your prescriptions filled at a non-participating pharmacy.
2. Submit this form to the address below as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to keep the form until completely filled.

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under **Cardholder Information.** Transfer the Cardholder Identification Number, Member Number (if applicable) and Group Number from your identification card.
2. A separate claim form must be completed for each **patient.**
3. Have your pharmacist complete the **PRESCRIPTION INFORMATION** section for each prescription filled and the **PHARMACY INFORMATION** section. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or your receipt.
4. **IMPORTANT:** The drug quantity, drug name and strength **or** eleven digit National Drug Code (NDC) is required and **must** appear on your submitted claim(s) or receipt(s).
5. **The original paid pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory proof of purchase.**
6. **FOR COMPOUNDED PRESCRIPTIONS ONLY:** Ask your pharmacist for assistance. The NDC number appearing on the claim should be that of the most expensive prescription ingredient. Should you have more than one compounded prescription, please use additional claim forms.
7. Claim forms submitted without the required information can cause payment delays and result in the information being returned for completion.

C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to: Your Benefit Manager at your company or:

   Amwins Rx - DMR
   7835 Freedom Avenue NW
   North Canton, OH 44720

2. Or you can fax this form and your receipts to 866-646-1403 Attn: DMR Department.
3. Please allow up to four weeks for processing and payment of your claims. For Part D claims, please allow up to 14 days for processing and payment of your claims.
4. You may call 1-800-580-4403 between 8:00 AM and 8:00 PM (Eastern Time) for questions or problems concerning your submitted claims.

CLAIMS WITH MISSING OR ILLEGIBLE INFORMATION WILL BE RETURNED

GENERAL FRAUD NOTICE: NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD NOTICE: <u>For the states of AL, AZ, AR, CO, DE, DC, FL, GA, IN, KS, KY, LA, MD, ME, NC, NE, NH, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:</u>

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arizona: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Georgia, Oregon, Vermont: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Nebraska: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false, incomplete or misleading information is guilty of insurance fraud.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Carolina: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.