DMBA

150 Social Hall Avenue, Suite 170
P.O. Box 45530 • Salt Lake City, Utah 84145
Telephone: 801-578-5600 • Toll free: 800-777-3622
Fax: 801-578-5901 • Website: www.dmba.com

PRESCRIPTION CLAIM FORM

TO AVOID DELAY, ANSWER ALL QUESTIONS (INSTRUCTIONS ON BACK)

A. PARTICIPANT INFORMATION

Participant name:_____ Birth date (mm/dd/yy): _____

DMBA ID number: _____

Address: _____

Home telephone: _____ Work telephone: _____

Patient's name: _____ Birth date (mm/dd/yy): _____

Patient's relationship to participant: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Number of receipts submitted:_____

Receipt dates: _____

B. OTHER INSURANCE INFORMATION

Is the patient covered by any other group insurance, health maintenance organization (HMO), or government plan (including Medicare)? ❑ Yes (complete the following information) ❑ No (proceed to section C)

Insurance company name: _____

Policy holder's name: _____

Policy number:_____

C. AUTHORIZATION

I certify this information is true and complete. I authorize DMBA, healthcare providers, and/or persons or entities retained by DMBA for the purpose of auditing claims to secure or release information relating to this claim. I understand, agree, and consent that this authorization shall remain in effect indefinitely.

(Coordination of benefits may occur at the time you pay for your prescription. For more information, call DMBA.)

Signature:_____ **Date (mm/dd/yy):** _____

PLEASE SEE THE BACK OF THIS FORM

HELP US PROCESS YOUR CLAIM

1. Attach itemized receipt(s) from the pharmacy. An itemized receipt includes:
   - Date the prescription was filled
   - Medication name and strength
   - Quantity of medication received
   - Pharmacy name and telephone number
   - Copayment amount or amount you paid for the medication
   - NDC 11 (National Drug Code) for the medication (except on foreign claims)
2. Complete and sign a *Prescription Claim Form* for each patient.
3. Claims **must be submitted within 12 months** from the date the prescriptions were filled. Claims received after this date will not be eligible for benefits.
4. For faster processing, put receipts in date order and separate each year.
5. Send the claim form and related receipts to:

DMBA
P.O. Box 45530
Salt Lake City, Utah 84145

When the claim has been processed, you will receive an *Explanation of Benefits* (EOB) explaining how your claim has been handled. If you have any questions, please contact DMBA:

Salt Lake City area. 801-578-5600
Toll free 800-777-3622