HAMASPIK, INC.

Reimbursement Form

Directions

1. This form must be completely filled out to process your claim(s)
2. Attach a copy of all prescription receipt(s) to the back of this form
3. Please submit within 3 years from the date the prescription was obtained
4. Prescription receipts should contain as much of the following information as possible;
   a. Prescription number and date filled
   b. Pharmacy name and telephone number
   c. Drug name and strength
   d. Quantity, day supply and amount paid

5. Mailed:
   Magellan Rx Management
   P.O. Box 1167
   Maryland Heights, MO 63043

   OR Faxed:
   1-866-272-4092

6. If you have any questions please contact us, Magellan Rx Management at **1-800-424-4437** (TTY users call 711). We are available 24 hours a day, 7 days a week.

Member Information

Member Full Name:	Member ID Number:
Mailing Address:	Phone Number:
City: State:	Zip:

You did not receive coverage at the pharmacy because:

- ☐ You have not received your ID Card
- ☐ The pharmacy is not in the Magellan Rx network
- ☐ The pharmacy cannot process the claim electronically
- ☐ It was an emergency - Please describe the emergency on a separate sheet
- ☐ The pharmacy or payer system was down
- ☐ You did not have your ID card and the pharmacy could not verify eligibility
- ☐ There were not any network pharmacies available where the prescription could be filled
- ☐ Other - Please describe on a separate sheet

Other Insurance Coverage Information
Are you eligible for primary prescription drug coverage from another insurance company?
☐ Yes
☐ No
Other Insurance Company's Name:
Group Number:
Member ID Number:
Effective Date of Coverage:

Prescription Information							
#	Rx Number	NDC Number	Compound Y/N	Date Filled (mm/dd/yyyy)	Drug Name/Strength	Amount Paid	Quantity/Day Supply
1							
2							
3							
4							

Pharmacy Information			
#	Pharmacy Name	Pharmacy Phone Number	Pharmacy NPI Number
1			
2			
3			
4			

Prescriber Information				
#	Prescriber Name	NPI Number	Phone Number	State
1				
2				
3				
4				

Enrollee Signature

Notice: Reimbursement for this drug claim is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription drug plan and will be for the amount your program would have paid on your behalf if the prescription drug is covered.

Any person who knowingly and with intent to defraud, injure or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act, which may subject such a person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or the individual for whom I am the Authorized Representative) have received the medicine described herein. I certify that I have read and understood this form, and that all the information included on this form is true and correct.

Signature: _____ **Date: _____**

REMINDER:
To avoid having to submit a paper claim

- ✓ Always have your prescription drug card at the time of purchase
- ✓ Always use pharmacies in your network
- ✓ Use medication covered under your formulary