

**THE
EMPIRE
PLAN**

Enrollee Information See your prescription drug ID card.

Enrollee ID

Street Address

City _____ State _____ ZIP _____

Date of Birth

Name of Pharmacy

Street Address

[illegible]

City _____ State _____ ZIP _____

Telephone (include area code)

True out-of-pocket (TrOOP) Update: We would like to know if you have other coverage from one of these payors [please check only one and complete the "Other Coverage Section" on the back page]. Please include all pharmacy receipts and/or Explanation of Benefits when requesting a manual TrOOP update (see Other Coverage Section on back).

- ☐ A discount card
- ☐ A Patient Assistance Program (PAP)
- ☐ A secondary payor
- ☐ Other

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X
Signature of Enrollee

(Another Health Plan has paid a portion)
Mark the appropriate box for your
primary coverage method. See the back
for more information.

Is this a coordination of benefits claim?

- ☐ Yes ☐ No
- ☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
- ☐ Card Program
- ☐ Medco By Mail/mail-order pharmacy

Other Coverage Section: (complete the information below if the patient has other **prescription drug coverage programs**)

Other Insurance Company Name

Other Policy Number

Other Policy Holder Name

Date of Service	Drug Name – Rx Number	Charge	Amount Patient Paid	Amount Other Payor Paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the “metric quantity” expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.

RX#	Date Filled	Days' Supply
VALID 11-digit NDC#		Quantity
Total Quantity		
Total Charge		

When To Use This Form

- Use this form to submit claims under Coordination of Benefit Rules.
- You must complete a **separate** claim form for **each pharmacy** used.
- You must submit claims no later than 3 months after the end of the benefit year for the date of purchase in accordance with the Centers for Medicare and Medicaid Services (CMS).

Other Coverage Paid

You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipt(s) on a blank sheet of paper, and enclose the EOB from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

Card Program: If the primary plan is one in which a co-payment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and tape the prescription receipt(s) on a blank sheet of paper that shows the co-payment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

Medco By Mail/mail-order pharmacy: If the primary plan is **Medco By Mail**, complete this form and include either the prescription receipt(s) that show(s) the co-payment or coinsurance amount paid to the mail-order pharmacy, or the statement of benefits you receive from the mail-order pharmacy.

Instructions

- Read carefully before completing this form
- Receipts should contain the following information:**
 - Date prescription filled
 - DAW (Dispense As Written)
 - Name and address of pharmacy
 - Doctor name or ID number
 - Amount paid
 - Name of drug and strength
 - Quantity and days' supply
 - Prescription number (Rx number)
 - NDC number (drug number)
 - The plan member should read the acknowledgment carefully, then sign and date this form.
 - Return the completed form and receipt(s) to:
Medco Health Solutions, Inc.
P.O. Box 14718
Lexington, KY 40512
 - If you have questions about how to complete this form, you may call toll-free at 1 877 7 NYSHIP (1 877 769-7447).

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 is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

- * California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- * 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.