Reset Form Print Form

University of Michigan Prescription Drug Claim Form

This claim will not be processed until this form and accompanying receipts are submitted.

INSTRUCTIONS FOR COMPLETING PRESCRIPTION DRUG CLAIM FORM

1. Complete all sections of the claim form below.
2. Submit a claim form with each request.
3. Include copies of pharmacy receipts and register receipts. The pharmacy receipts must show the following prescription information for each expense:
   - Pharmacy Name and Address
   - Prescription Number
   - Drug Name, Strength, and NDC
   - Drug Cost
   - Patient's Name
   - Fill Date
   - Quantity and Days' Supply
   - Amount Paid Out-of-Pocket
4. Mail or fax the completed form and accompanying receipts to:

   Magellan Rx Management
   Attention: Claims Department
   P.O. Box 1599
   Maryland Heights, MO 63043

   Fax: 1-866-291-3732
5. Call Customer Service at **1-888-272-1346** if you have any questions.

POLICYHOLDER AND PATIENT INFORMATION

Policyholder or Insured's Name *(First, Middle, Last):* _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policyholder or Insured's ID No. *(as shown on ID Card)*: _____

Why was the insurance or drug card not used for this purchase? _____

Patient's Name *(First, Middle, Last)*: _____

Patient's Date of Birth: _____ Patient's Sex: ☐ Male ☐ Female

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

OTHER INSURANCE INFORMATION

Is the patient eligible for any other Prescription Drug Coverage? ☐ Yes ☐ No

If *YES*, does the coverage include: ☐ Major Medical ☐ Drug ☐ Other Medical

Insured's Name: _____

Insured's Date of Birth: _____

Insured's ID Number: _____ Effective Date: _____

Insurance Company Name: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to University of Michigan powered by Magellan Rx Management, its agents, or representatives.

Signature: _____ **Date:** _____

umich.magellanrx.com

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University of Michigan

Magellan Rx Management℠