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| [https://www.aruplab.com/files/images/event-logos/arup.png](https://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0CAcQjRxqFQoTCOfZrsnO3sgCFcU4iAodx28FtA&url=https://www.aruplab.com/education/weber-cls&bvm=bv.105841590,d.cGU&psig=AFQjCNGyjHHVih_-EsyJUMkchq07Vu4gfw&ust=1445896558167277) | **Prescription Drug**  **Claim Form for**  ARUP Laboratories Claim Form | | | | | *When Completed Return To:*  ProCare PBM  Attn: Claims Reimbursement  1267 Professional Parkway  Gainesville, GA 30507  Member Services: 1-855-828-1483  Fax: (678) 281-7586 | |
| **A. – Insured / Patient Information:** | | | | | | | |
| Cardholder’s Last Name First Name Middle Initial | | Plan Name | Cardholder Identification Number | | | | Today’s Date      /     / |
| Address | | | | | | | |
| City, State, ZIP | | | | | | | |
| Telephone:  Home: ( ) - Work: ( ) - | | | | | | | |
| Mailing Address (Patient’s Address if payment should be mailed to a different address than above for Cardholder) | | | | | | | |
| City, State, ZIP (Patient’s Address if payment should be mailed to a different address than above for Cardholder) | | | | | | | |
| Patient’s Last Name Patient’s First Name Middle Initial | | Date of Birth        /       / | | | Patient’s Sex  Male Female | | Relationship to Cardholder  Self  Dependent  Spouse  Other |
| Employer Name | | | | Group Number | | | |
| Employer Address, City, State, Zip | | | | | | | |
| Do you or any member of your immediate family have other group insurance which may cover all or part of this claim?  Primary Coverage:  Yes  No Secondary Coverage:  Yes  No | | | | If yes, give the insurance company name and group number: | | | |

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| **B. – Claim Information: Important – Submit either Prescription receipts / labels or patient history print-out from your Pharmacy** | | | | |
| Pharmacy ID# | Pharmacy Name | Fill Date        /       / | Rx Number: | Metric Quantity |
| Days Supplied | NDC# | Prescriber | | Charge |

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| Pharmacy ID# | Pharmacy Name | Fill Date        /       / | Rx Number: | Metric Quantity |
| Days Supplied | NDC# | Prescriber | | Charge |

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| Pharmacy ID# | Pharmacy Name | Fill Date        /       / | Rx Number: | Metric Quantity |
| Days Supplied | NDC# | Prescriber | | Charge |

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| Pharmacy ID# | Pharmacy Name | Fill Date        /       / | Rx Number: | Metric Quantity |
| Days Supplied | NDC# | Prescriber | | Charge |

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| **C. – Reason for Claim Submission or Special Notes:** |

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| **D. – Authorization:** |

I certify that the above information is true and correct to the best of my knowledge and hereby authorize any physician, pharmacy, employer, union, insurance company or HMO to supply any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Signature Date Signed

**PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND FILL OUT REVERSE SIDE OF THIS FORM.**

**SECTION A – INSURED / PATIENT INFORMATION:** (Complete this section for each family member who has received medication)

1. Print Cardholder’s name (last, first, middle initial)

2. Print Cardholder’s Identification Number (found on prescription drug or health insurance card)

3. Print Today’s Date

4. Print Cardholder’s Address Information and Phone Numbers

5. Print Mailing Address (Patient’s address, if payment should be mailed to a different address than the Cardholder’s address above)

6. Print Patient’s name (last, first, middle initial)

7. Patient’s Date of Birth, Patient’s Sex and Check Relationship to Cardholder (Self, Spouse, Dependent, Other)

8. Print Employer Name, Group Number and Employer Address information (refer to drug or health insurance card)

9. Indicate if covered under another drug plan, include the insurance company name and group number

**SECTION B – CLAIM INFORMATION:**

Submit either prescription receipts/labels with this claim form or a patient history print-out

from your pharmacy. It is preferable to have them unattached. Please don’t staple, tape or glue.

Claims received missing any of the following information may be returned or payment may be denied:

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| * **Pharmacy ID#** - 7 digit Pharmacy Identifier (NABP#) * **Pharmacy Name** – Pharmacy Name * **Fill Date** – Date Drug was dispensed * **Rx Number** – Prescription Number * **Metric Quantity** – Quantity of the drug dispensed * **Days Supply** – The number of days supply of the drug dispensed * **NDC #** - 11 digit drug code * **Prescriber** – Prescribing physician’s name * **Charge** - Amount paid for the prescription |

**Note: Altered receipts require pharmacist’s signature.**

**SECTION C – REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:**

This section can be used for special notes or comments.

**SECTION D – AUTHORIZATION:**

Insured’s Signature and Date Signed

IMPORTANT: Claim form must be signed. (Unsigned claim forms cannot be processed and will be returned)

Questions? Call ProCare PBM Member Service Department at 888-821-5516

Please return this claim to: ProCare PBM

Attn: Claims Reimbursement

1267 Professional Parkway

Gainesville, GA 30507