



Please submit claim forms to:

The ODS Companies

Attn: Pharmacy

P.O. Box 40327

Portland, OR 97240-0327

Prescription Drug Claim Form

Group # _____ Subscriber ID Number

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Subscriber Name _____

Please Print _____
Address City State Zip

Is this medication for an on-the-job injury? Yes No

Does this patient have prescription coverage under any other group insurance plan? Yes No

If yes, provide the name of the insurance company. _____

Phone number _____ Name of Insurance Company _____

ID number _____ Group number _____

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Signature _____

Please attach a receipt that includes the following information, or have your pharmacist complete and sign the sections below. Important: If this claim is for a compounded medication, please have your pharmacist complete both pages of this form.

Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx Directions	Days Supply
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Medication Name, Dosage, Form & Strength	Physician's name and NPI #
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NDC Number (11-digit)	Rx Price Plus Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No
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Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx Directions	Days Supply
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Medication Name, Dosage, Form & Strength	Physician's name and NPI #
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NDC Number (11-digit)	Rx Price Plus Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No
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PHARMACY INFORMATION

Pharmacy Name	Ten-digit NPI Required <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>										

Address _____

City State Zip _____

Pharmacy telephone number _____ fax number _____



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Prescription Drug Claim Form (con't) for Compounded Prescriptions Only

If your prescription is for a compounded drug, ask your pharmacist to fill out this form. Mail this form along with Prescription Drug Claim Form (page 1) and a receipt.

For Pharmacy use only

- >Enter the NDC number of the most expensive ingredient of the legend drug used.
- >Indicate the drug ingredient(s) and quantity.
- >Indicate the metric quantity dispensed in number of tablets, grams or mls for liquids, creams, ointments, and injectables.
- >Indicate the amount paid for the prescriptions by the patient.

Compounded Prescription Chart.....			
NDC#	Drug Ingredient	Quantity	Charge
TOTAL			\$

IMPORTANT: The original Pharmacy prescription label/receipt (including the required drug information) must accompany this claim form. Please do not highlight receipts or items on this form as this will not show on scanned images and may cause delayed processing of your claim. Pharmacy receipts will not be returned, it is recommended that you make copies for your own records.