Prescription Drug Claim Form

SECTION A: Employee Information

Employee's Full Name _____ Employee's ID#: _____

Home Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip: _____ Employee Name: _____

Employer Group#: _____

☐ Check if new address

I certify that all information provided is correct and that the prescription(s) submitted are for myself or members of my family who are eligible. The patient(s) listed below has(have) received the medication, and I authorize release of all information contained on this claim to Paragon Benefits, Inc. and my Employer.

Employee's Signature: _____ Date: _____

SECTION B: Patient Information

Complete this section for each eligible family member who received medication for which you are submitting claims at this time

Patient's Name (Last,First,MI)	Relationship to Employee	Gender	Itemized Medical Bills	Total $ Amount for Patient
	☐ Self ☐ Dependent ☐ Spouse ☐ Other			$
	☐ Self ☐ Dependent ☐ Spouse ☐ Other			$
	☐ Self ☐ Dependent ☐ Spouse ☐ Other			$
	☐ Self ☐ Dependent ☐ Spouse ☐ Other			$
			TOTALS FOR ALL PRESCRIPTIONS:	$

SECTION C: Prescription Information

IMPORTANT: Submit either prescription receipts/labels with this claim form or a patient history print-out from your pharmacy. Claims missing any of the following information may be returned or payment may be denied. Also, attach itemized bills from doctor's offices who do not file insurance claims

Pharmacy Claims: Pharmacy Name/Address; Date Filled; Drug Name and Strength; RX Number; Quantity; Price

NOTE: Altered receipts require signature.

SECTION D: Other Coverage Information (Specific coordination of benefits form available upon request.)

Is coverage for this claim provided by any other group insurance, federal program, or any other insurance program? ☐ Yes ☐ No

Name of other Carrier _____

Policyholder's Name: _____

Have these claims been processed by the other carrier? ☐ Yes ☐ No

SECTION E: Reason For Claim Submission Or Special Notes:

_____

_____

_____

Mail the completed claim to: **Paragon Benefits, Inc.**
P. O. Box 12288 Columbus, GA 31917
Phone: 1.800.277.9218
You may also FAX this form and all receipts to:
1.706.256.4089

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