



# Prescription Drug Reimbursement Form

### CARD HOLDER INFORMATION

Submission Date: \_\_\_\_\_

Member ID No.: \_\_\_\_\_ Name: \_\_\_\_\_  
 (First) (Middle Initial) (Last)

Address: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Plan Name: Neighborhood Health Plan  
 (Day time number)

A separate claim must be completed for each patient and for each pharmacy.

### PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Relationship to Card Holder: \_\_\_\_\_

### PRESCRIPTION INFORMATION

Pharmacy ID (NPI) NO.: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim No.: **ONE** Prescription No.: \_\_\_\_\_ Date Filled: \_\_\_\_\_ Prescription: New Refill

Drug Name: \_\_\_\_\_ Product ID (NDC) No.: \_\_\_\_\_

Quantity: \_\_\_\_\_

Days Supply: \_\_\_\_\_ Total Charge: \_\_\_\_\_ Prescribers Name or NPI No.: \_\_\_\_\_

Claim No.: **TWO** Prescription No.: \_\_\_\_\_ Date Filled: \_\_\_\_\_ Prescription: New Refill

Drug Name: \_\_\_\_\_ Product ID (NDC) No.: \_\_\_\_\_

Quantity: \_\_\_\_\_

Days Supply: \_\_\_\_\_ Total Charge: \_\_\_\_\_ Prescribers Name or NPI No.: \_\_\_\_\_

Claim No.: **THREE** Prescription No.: \_\_\_\_\_ Date Filled: \_\_\_\_\_ Prescription: New Refill

Drug Name: \_\_\_\_\_ Product ID (NDC) No.: \_\_\_\_\_

Quantity: \_\_\_\_\_

Days Supply: \_\_\_\_\_ Total Charge: \_\_\_\_\_ Prescribers Name or NPI No.: \_\_\_\_\_

**After completing all three sections above, please mail this form and paid pharmacy receipt to:**  
**MedMetrics Health Partners – Attn: Member Services**  
**100 Century Dr, Suite A, Worcester, MA 01606-1244**  
**Fax to: 800 918-7556**

For questions regarding your submitted reimbursement, contact NHP Member Service Center at 800-462-5449  
**Reminder: A completed form must be submitted along with prescription receipts**