CITIZENS Rx™

Powered by LucyRx

Direct Reimbursement Claim Form

HOW TO COMPLETE THIS FORM

Complete the following

PART ONE

Subscriber Information

1. Copy the Subscriber (Member) ID from the ID Card.
2. Subscriber name, address (including city, state, and zip) and daytime phone number.
3. Patient Name: Person drug was prescribed for.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female
6. Status: Patient's relationship to subscriber. If other, please write in type of relationship.
7. Please use separate claim form for each family member.

PART TWO

Coordination of Benefits (COB)

1. If you **do not** have Coordination of Benefits (COB) coverage, Check No.
   If you **do** have COB coverage, check Yes, complete Part Two, and attach a **copy** of: Explanation of Benefits (EOB) or statement from other coverage and/or pharmacy receipt.
2. Name of insured policyholder.
3. Name of insured's employer.
4. Name of other insurance company (if applicable).
5. Insurance policy number from other insurance company (if applicable).

PART THREE

Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. Pharmacy ID (NCPDP #): Obtain the number from the pharmacy where prescriptions were purchased.
3. **Attach pharmacy receipts to the form in the space provided.** The receipts must indicate date of service, Rx number, NDC number, quantity, days supply and the amount paid.
4. Use a separate claim form for each pharmacy from which you purchase prescriptions.
   Note: Claim submission is not a guarantee of payment.

MAIL THIS FORM TO

LucyRx

7815 N Palm Avenue, Suite 400

Fresno, CA 93711

CITIZENS Rx™

Powered by LucyRx

Direct Reimbursement Claim Form

PART ONE: To be completed by you

SUBSCRIBER ID

SUBSCRIBER NAME

MAIL ADDRESS STREET

CITY STATE ZIP

DAYTIME PHONE NUMBER

PATIENT'S NAME

/ /

PATIENT'S DATE OF BIRTH (MM/DD/YYYY)

SEX: ☐ **MALE** ☐ **FEMALE**

RELATIONSHIP:

☐ **SUBSCRIBER** ☐ **SPOUSE** ☐ **CHILD**

OTHER: _____

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for the treatment of an on-the-job injury, or covered under another benefit plan unless Part Two is completed. I authorize release of all information pertaining to this claim to Citizens Rx, LLC, the plan administrator, insurance underwriter, plan sponsor, policyholder, and/or employer. I certify that all the information entered on this form is correct.

X

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE.

PART TWO: Coordination of Benefits (COB)*: To be completed by you

HAS YOUR CLAIM BEEN PROCESSED WITH ANOTHER INSURANCE CARRIER?

☐ NO If no, you can skip the remainder of Part Two.

☐ YES If yes, attach a **copy** of: your EOB or statement from the other coverage and/or your receipt from the pharmacy.

NAME OF INSURED POLICYHOLDER

NAME OF INSURED'S EMPLOYER

NAME OF OTHER INSURANCE COMPANY

POLICY NUMBER (OTHER INSURANCE COMPANY)

TYPE OF COVERAGE: ☐ SINGLE ☐ FAMILY

**** YOUR POLICY/PLAN MUST HAVE A PHARMACY COB CLAUSE IN ORDER TO COORDINATE BENEFITS.***

PART THREE: Pharmacy Information - To be completed by you or your pharmacist

PHARMACY NAME

MAILING ADDRESS STREET

PHARMACY ID (NCPDP #)

CITY STATE ZIP

( )

PHARMACY TELEPHONE

FOR COMPOUNDS

For Compounds: Pharmacist to identify the specific prescription by date of service and Rx number. Please list name, NDC# and metric quantities of each ingredient in box on left.

X

SIGNATURE OF PHARMACIST FOR COMPOUNDS