

Gold Net

PRESCRIPTION DRUG CLAIM FORM

See Instructions on the following page

EMPLOYEE INFORMATION

Carrier #

P	G	I	G	N
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 Group #

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 ID #

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 Pt Code

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Employee Name: _____ Street Address: _____
City: _____ State: _____ Zip: _____ Employer/Company Name: _____

I certify that the information is correct and that the patient indicated below is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this claim form to Gold Net. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

- Is this medication for an on-the-job injury? Yes No
- Is this medication covered under any other medical plan? Yes No

PATIENT/EMPLOYEE SIGNATURE: _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ / ____ / ____ Male Female

Patient's Relationship to Insured:

Self Spouse Dependent

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

PRESCRIPTION CLAIM INFORMATION

1 RX #: _____ New Refill Date Filled: ____ / ____ / ____ Quantity: _____

Days Supply (number of doses per day): _____ Name of Medication: _____

NDC#:

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 Form of Medication (capsules, cream, etc.) _____

Drug Manufacturer: _____ Strength (250 mg., etc.): _____

Prescription Cost: \$ _____ Prescribing Physicians Name: _____

2 RX #: _____ New Refill Date Filled: ____ / ____ / ____ Quantity: _____

Days Supply (number of doses per day): _____ Name of Medication: _____

NDC#:

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 Form of Medication (capsules, cream, etc.) _____

Drug Manufacturer: _____ Strength (250 mg., etc.): _____

Prescription Cost: \$ _____ Prescribing Physicians Name: _____

3 RX #: _____ New Refill Date Filled: ____ / ____ / ____ Quantity: _____

Days Supply (number of doses per day): _____ Name of Medication: _____

NDC#:

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 Form of Medication (capsules, cream, etc.) _____

Drug Manufacturer: _____ Strength (250 mg., etc.): _____

Prescription Cost: \$ _____ Prescribing Physicians Name: _____

INSTRUCTIONS

- This form is to provide direct reimbursement for prescriptions that were purchased without the use of your Gold Net card.
- **In order to process your claim(s) in the most timely manner, you must provide all information requested.**
- Contact your pharmacist, if necessary, to provide the detailed drug information requested. Rx receipts of a pharmacy generated drug summary must be attached.
- Use your Gold Net card to obtain your identification numbers.
- Please use a separate claim form for each patient. In addition, use a separate claim form for each pharmacy visited.
- To order additional claim forms, call your customer service representative.
- Please do not enclose more than three prescriptions per claim form unless you have a drug summary.
- Mail claim form to: Gold Net, P.O. Box 64338, St. Paul, MN 55164-0338.