MEDTRAK MEMBER CLAIM FORM
Instructions for this form are on the reverse side.

MEMBER INFORMATION (member is the person for whom the prescription was written)

The member is the: ☐ **Cardholder** ☐ **Spouse** ☐ **Dependent**

Member Name: ____ **Date of Birth:** _________________

Cardholder ID number: ____

Member mailing address: ____

____

You will be notified by e-mail when we have received and processed your claims.
This e-mail will not contain any personal health information or drug names.

My e-mail address is: ____

We will only contact you by phone should we need more information in order to process your reimbursement request.

My daytime phone number is**:** ____

Total number of individual prescription claims you are submitting for reimbursement: _______

IMPORTANT: You must submit a Pharmacy receipt or a Pharmacy printout for each claim that includes: Name, address, and phone number of pharmacy; date prescription was filled; prescription number; NDC number; drug name and strength; quantity; days supply; and the dollar amount you paid to the pharmacy.

IMPORTANT: Failure to provide all the above information will delay the processing of your claims

It is to your advantage to have the pharmacy submit the claims on-line to MedTrak whenever possible. Provide the reason(s) your pharmacy did not submit the claims directly to MedTrak:

☐ I used an Out of Network Pharmacy ☐ Prescription was for Compound Medication

☐ I did not have my card ☐ I was out of town

☐ The Pharmacy could not, or would not, submit the claim directly to MedTrak.

☐ Other (please explain):

Unless the member is a minor (17 or younger) this form must be signed by the person for whom the prescriptions were written, otherwise the Cardholder must sign**. By signing below, I certify the above information is correct.**

Member Signature: ____ Date: ________________

You can mail completed form to:
MedTrak Services
Attn: Keyed Claims Dept.
7101 College Blvd. Suite 1000
Overland Park, KS 66210

You can fax completed form to:
MedTrak Services
Attn: Keyed Claims Dept.
Fax number is 866-552-8939

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Instructions for completing the MedTrak Member Claim Form

All information must be provided in order to accurately process your claim(s).
Incomplete or illegible information will result in form being returned or payment delays.

MEMBER INFORMATION

- The member is: Check only one: cardholder, spouse, or dependent.
- Member Name: Enter the person for whom the prescription was written. This is either the cardholder, the spouse of the cardholder, or a dependent of the cardholder.
- Date of Birth: Enter the birth date of person for whom the prescription was written.
- Cardholder ID: Enter the member Identification Number assigned to you by MedTrak.
- Address: Enter permanent mailing address.
- Contact info: Provide e-mail address and daytime phone number.

PRESCRIPTION INFORMATION

- Please indicate the total number of individual prescriptions you are submitting for reimbursement. This number should be the same number of attached receipts and/or line items on a printout.
- Most Pharmacies supply a receipt for each individual prescription which includes the required information. If you have lost a receipt, or have multiple claims, the Pharmacy can supply you with a printout of prescriptions for a given time period. Either the receipt or the printout will be sufficient if it provides the following information:
  1. The name, address, and phone number of the pharmacy.
  2. The date the prescription was filled.
  3. The number assigned to the prescription by the Pharmacy (prescription number).
  4. The National Drug Code (NDC), which identifies the drug product dispensed.
  5. The name and strength of the drug dispensed.
  6. The quantity of the product dispensed.
  7. The number of days the dispensed quantity is expected to last.
  8. The dollar amount the member paid the Pharmacy for the prescription.
- **Cash register receipts do NOT have the information required to process a claim.**

MEMBER SIGNATURE AND DATE

The completed form must be signed by the member (person who received the prescriptions) unless the member is a minor (17 or younger) or is incapable of signing form. In cases where the member is a legal dependant of the cardholder, the cardholder should sign the form. By signing the form, the member is certifying the information submitted is correct.

IMPORTANT INFORMATION

Being able to submit paper claims to MedTrak for manual "keying" and potential reimbursement is part of your prescription benefit package. In situations where the pharmacy can not or will not submit on-line to MedTrak, we are happy to process those claims manually based on the guidelines of your plan design

- **The amount of reimbursement received may be less than the member paid at the pharmacy based on a number of variables including plan design, deductibles, co-payments, and discounted price of drug.**
- **Reimbursement takes approximately eight weeks from the time the claim is submitted to the time the member receives the check.**
- **When the claim is submitted "on-line" to the pharmacy, the member is responsible only for deductibles and co-payments determined by the plan design.**

If you need assistance completing this form or have questions regarding this reimbursement process, a MedTrak Pharmacy Benefit Advisor can be reached at 800-771-4648.