

INSTRUCTIONS

PARTICIPANT/PATIENT INFORMATION - To Be Completed by the Participant

1. Complete ALL information in the top section.
2. Sign and date the Certification Statement in the area provided.
- Fold 3. Complete the RETURN ADDRESS section below.
4. Submit a separate form for each family member.
5. The lower section must be completed in full for each prescription dispensed. If you have questions regarding the information needed to complete the form, contact your pharmacist.
6. Keep a copy for your records.
7. Mail the claim form within 180 days of the prescription fill date, along with original receipts, to:

CIGNA
RxPRIME CUSTOMER SERVICE - A121
900 COTTAGE GROVE ROAD
HARTFORD, CT 06152-1121

8. Questions? Call RxPRIME Customer Service at **1-800-6-CALL-RX (or 1-800-622-5579)**

RETURN ADDRESS

**IMPORTANT: PLEASE PRINT. THIS WILL APPEAR IN A WINDOW ENVELOPE FOR RETURNS.
PLEASE PROVIDE CURRENT ADDRESS INFORMATION BELOW:**

PARTICIPANT NAME

PARTICIPANT STREET ADDRESS

PARTICIPANT CITY, STATE, ZIP

PRESCRIPTION DRUG CLAIM FORM - RETAIL CARD



→ NOTE: This claim form can be used to request reimbursement of covered expenses for: ←

- 1) Non-Network Prescription Purchases
- 2) In-Network Prescription Purchases for which you paid full price.

PARTICIPANT NAME: _____ **EMPLOYER:** _____

PARTICIPANT SOCIAL SECURITY NUMBER: _____

PATIENT NAME: _____ **PATIENT BIRTHDATE:** ____ / ____ / ____
MO DAY YEAR

-USE A SEPARATE FORM FOR EACH FAMILY MEMBER-

PATIENT RELATIONSHIP TO PARTICIPANT: ____ SELF (PARTICIPANT) ____ SPOUSE ____ DEPENDENT

PATIENT SEX: ____

PARTICIPANT SIGNATURE: _____ **DATE:** _____

I CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT THE PATIENT HAS RECEIVED THE MEDICATION DESCRIBED. I ALSO CERTIFY THAT THE MEDICATION RECEIVED IS NOT FOR TREATMENT OF AN ON-THE-JOB INJURY. I ALSO AUTHORIZE RELEASE OF ALL INFORMATION PERTAINING TO THIS CLAIM TO THE PLAN ADMINISTRATOR OR ITS DESIGNEES.

<p>①</p> <p>____ / ____ / ____ DATE FILLED RX NUMBER QTY DAYS SUPPLY</p> <p>____ NATIONAL DRUG CODE</p> <p>____ PHARMACY NABP #</p> <p>\$ AMOUNT MEMBER PAID</p>	<p>②</p> <p>____ / ____ / ____ DATE FILLED RX NUMBER QTY DAYS SUPPLY</p> <p>____ NATIONAL DRUG CODE</p> <p>____ PHARMACY NABP #</p> <p>\$ AMOUNT MEMBER PAID</p>
<p>③</p> <p>____ / ____ / ____ DATE FILLED RX NUMBER QTY DAYS SUPPLY</p> <p>____ NATIONAL DRUG CODE</p> <p>____ PHARMACY NABP #</p> <p>\$ AMOUNT MEMBER PAID</p>	<p>④</p> <p>____ / ____ / ____ DATE FILLED RX NUMBER QTY DAYS SUPPLY</p> <p>____ NATIONAL DRUG CODE</p> <p>____ PHARMACY NABP #</p> <p>\$ AMOUNT MEMBER PAID</p>
<p>⑤</p> <p>____ / ____ / ____ DATE FILLED RX NUMBER QTY DAYS SUPPLY</p> <p>____ NATIONAL DRUG CODE</p> <p>____ PHARMACY NABP #</p> <p>\$ AMOUNT MEMBER PAID</p>	<p>⑥</p> <p>____ / ____ / ____ DATE FILLED RX NUMBER QTY DAYS SUPPLY</p> <p>____ NATIONAL DRUG CODE</p> <p>____ PHARMACY NABP #</p> <p>\$ AMOUNT MEMBER PAID</p>