



Direct Reimbursement Claim Form

Please read carefully before completing this form.

Please tape pharmacy receipts to claim form. Payment will be delayed unless information is completed.

Mail completed forms to:

Quality Health Plans of New York
Attn: Pharmacy Department
6916 W. Linebaugh Ave., Suite 101
Tampa, FL 33625

Cardholder Information

Cardholder Last Name	Cardholder First Name	Cardholder Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Cardholder ID Number	Cardholder Group Number	Other Insurance (if any)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Cardholder Street Address	City	State/Prov. Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy Information

Pharmacy Name	NABP Number
<input type="text"/>	<input type="text"/>
Pharmacy Street Address	City State/Prov. Zip Code
<input type="text"/>	<input type="text"/>

Claim Information (1)

Date of Service	Rx Number	Name, Strength and Form of Medication	Amount Paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDC (National Drug Code)	Quantity	Day Supply	Physician's Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Physician's DEA
			<input type="text"/>

Claim Information (2)

Date of Service	Rx Number	Name, Strength and Form of Medication	Amount Paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDC (National Drug Code)	Quantity	Day Supply	Physician's Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Physician's DEA
			<input type="text"/>

Claim Information (3)

Date of Service	Rx Number	Name, Strength and Form of Medication	Amount Paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDC (National Drug Code)	Quantity	Day Supply	Physician's Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Physician's DEA
			<input type="text"/>

Claim Information (4)

Date of Service	Rx Number	Name, Strength and Form of Medication	Amount Paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDC (National Drug Code)	Quantity	Day Supply	Physician's Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Physician's DEA
			<input type="text"/>

I certify that patient information entered on this form is correct and the named patient is eligible for the benefits claimed and has received the medication described. I also certify that this medication received is not for treatment of an on-the-job injury. I authorize **Quality Health Plans of New York** to release all information pertaining to this claim to the Pharmacy Benefit Manager. I understand that payment of this claim will be made to the cardholder unless otherwise specified within this document. I also certify that I personally have incurred this expense and am entitled to reimbursement.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Patient or Guardian or Legal Representative: X _____

SIGNATURE REQUIRED FOR REIMBURSEMENT

Please Affix Pharmacy Receipt(s) Below

Attach Pharmacy Receipt
Here (1)

Attach Pharmacy Receipt
Here (2)

Attach Pharmacy Receipt
Here (3)

Attach Pharmacy Receipt
Here (4)

- Before you mail this form, be sure to:**
- Fill out the form completely
 - Sign your claim form
 - Attach all your pharmacy receipts

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