Boeing Drug Claim Form

PRIME THERAPEUTICS®

A. Member information (See other side for instructions)

ID number

Group number

Date of birth / / ❑ Male ❑ Female

Name (First, Last)

Street address

City State Zip

Member's relationship to primary cardholder:

❑ Self ❑ Spouse/Domestic partner ❑ Dependent/Child

If you are submitting this form for OTC COVID home test kits, skip to Section B.

I certify that:

- The information on this form is correct
- **The member named above is eligible for pharmacy benefits**
- The member named above received the medicine(s) listed
- These benefits have not been assigned; any further assignment is void
- I give my permission to share the information on this form with Prime Therapeutics LLC

X

Member or legal representative signature

Is this medicine for an on-the-job-injury? ❑ Yes ❑ No

Do you have other insurance for this prescription medicine? ❑ Yes ❑ No

If yes, what is the other insurance company's name?

Other insurance cardholder information (primary cardholder)

Name (First, Last)

Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

Prescription (Rx) claim information

Check reason for purchasing drug from a non-network pharmacy:

❑ I purchased this medicine outside the U.S.

❑ I became sick or ran out of my medicine while travelling outside my plan's service area (but still within the U.S.).

❑ I couldn't get a covered drug when I needed it because I couldn't find a 24-hour network pharmacy near me.

❑ The covered drug I needed is not usually stocked at a network retail (local) or home delivery pharmacy service.

❑ I couldn't use a network pharmacy because I was evacuated or displaced due to a federally declared disaster or health emergency.

❑ I couldn't choose a network pharmacy because I received the covered drug while in an ER department, medical clinic, or other outpatient setting (i.e. same-day surgery).

❑ None of the above, give reason below:

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach original itemized pharmacy receipts. (A cash register receipt is not acceptable.)

Rx number

Date filled / /

Quantity Days' supply

Name of medicine

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Prescription cost $.

B. OTC COVID test kit claim

To be reimbursed for a COVID home test kit, please attach itemized receipts to the back of this form. Please enter the NDC or UPC number from the cash register receipt. **All information below is required or your request will be denied and sent back to you for resubmission. There is a limit of 8 At-Home Rapid tests per 30 days.**

NDC or UPC number

Date purchased / / Quantity of tests ____

Test kit cost $.

IMPORTANT: You must sign the form, confirming that the test kit was not used for testing required by your employer, or for return to work, travel, admittance to a recreational event or resale.

NOTE: Claims are subject to your plan's limits, exclusions and provisions.

Signature

Instructions

1. Use a separate claim form for each member and prescription. All information provided on or attached to this claim form must be for the same person/prescription.
2. Attach original itemized pharmacy receipts provided with your prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Total charge
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

3. Required information for COVID-19 test kits:
   - Member name
   - ID number
   - Date of birth
   - Total test kit cost
   - NDC/UPC number
   - Quantity of test kits purchased
   - Date purchased
   - Itemized receipt
   - Signature
4. Send this completed form with itemized receipts to:

   Prime Therapeutics
   Mail route Commercial
   PO 25136
   Lehigh Valley, PA 18002-5136

Questions?

- You can call the number on the back of your member ID card
- Your pharmacist may call 800.821.4795

EXAMPLE

Rx number 0 0 0 0 0 6 0 1 1 4 8 1

Date filled 0 1 / 1 2 / 2 2

Quantity 30 Days' supply 3 0

Name of medicine "Drug Name"

NDC number 0 0 1 2 3 4 5 6 7 3 1

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number 0 1 2 3 4 5 6 7 8 9

(Does not apply for COVID home tests)

Prescription cost $ 2 0 5 . 1 4

Balance due $ 2 0 5 . 1 4

Is this prescription claim for a compound medicine?
❑ Yes ❑ No

Note: If yes, ask your pharmacist to complete the information below.

Compound Information

Please enter all information for each drug used.

Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx Receipts

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 or 3 above).

Keep a copy of this form and your receipt(s) for your records.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any health plan 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 health plan act, which is a crime and subjects such person to criminal and civil penalties.

Prime Therapeutics LLC is an independent limited liability company providing pharmacy benefit management services.