MERCYCARE HEALTH PLANS
MERCYCARE INSURANCE COMPANY • MERCYCARE HMO, INC.
P.O. BOX 2770, JANESVILLE, WI 53547-2770

Drug Reimbursement Claim Form

Instructions

Please complete all sections of the Drug Reimbursement Claim Form (DRCF) and attach the prescription receipt(s) for the medications dispensed. Acceptable prescription receipts include:

1. **Pharmacy medication claim printout, or**
2. **Individual pharmacy receipts that include the medication name, dosage form, Prescriber name, strength and quantity of medication prescribed, prescription number and medication cost.**

Insured (Subscriber) Information

Subscriber Name:_____
First MI Last

Subscriber Address:_____
Street City State Zip

Subscriber Phone Number:_____
Day Evening

Subscriber Member Number:_____

Patient Information

Patient Name:_____
First MI Last

Patient Member Number:_____

Patient Date of Birth:____/____/____Gender (Circle): Male Female

Relationship to Subscriber (Circle): Self Spouse Child Other

Please provide a brief explanation for the submission of claims:

_____

_____

Please note: If claims are being submitted for Coordination of Benefits (COB), please provide the following information:

1. **Pharmacy receipts/printout that identifies copays paid and**
2. **Explanation of Benefits from primary insurer**

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim to MercyCare Insurance Company for 90 days.

Signature:_____ **Date:**_____

Please allow 30 days for claims processing
If you have any questions, please contact our Customer Service Department at 1-800-895-2421. Fax- 1-608-741-5238

Send completed forms to:
MercyCare Health Plans
P.O. Box 2770
Janesville WI 53547-2770