evergreen HEALTH

Complete this form, attach prescription labels and mail to:
3000 Falls Rd Suite 400
Baltimore, MD 21211
(443) 451-4979

Subscriber Information

Member ID Number:	Group / Employer / Name and Number:
Subscriber Name: (Last, First, Middle)	Subscriber Birthdate: (MM/DD/YYYY)
Subscriber Address: (Street, City, State, Zip)	Subscriber Telephone Number:

Patient Information

Prescription(s) were for:

Patient Name: (First, Middle, Last)	Gender: ☐ Male ☐ Female	Employee Spouse Dependent ☐ ☐ ☐	Patient Birthdate (MM/DD/YYYY)

Reason for Request

☐ Eligibility Issues
☐ Coordination of Benefits
☐ Out-of-Area/Urgent Emergent Request
☐ Issues at the pharmacy (please describe)
☐ Compound claim
☐ Other (please describe)

Pharmacy Information

Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, Zip)	
Pharmacy Telephone Number:	Pharmacy Signature: Date:

Prescription Information

Please include the prescription labels *with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your* pharmacist *for assistance in completing the information below. Completing this entire form will result in timely processing of your claim. For questions concerning this claim please call phone number listed above.*

❶ Date Filled:	Rx Number:	Rx (check one) ☐ new ☐ refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #: Rx Price Paid:

❷ Date Filled:	Rx Number:	Rx (check one) ☐ new ☐ refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #: Rx Price Paid:

❸ Date Filled:	Rx Number:	Rx (check one) ☐ new ☐ refill	Quantity:	Day's Supply:	National Drug Code: (11 digits) | | | | | | | | | | |
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #: Rx Price Paid:

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature: Date: