



## Prescription Drug Claim Form

### SECTION A: Employee Information

Employee Full Name: \_\_\_\_\_ Employee's ID: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
 Check if new address Employer Group #: \_\_\_\_\_

I certify that all information provided is correct and that the claims submitted are for myself or members of my family who are eligible. The patient(s) listed below has (have) received the service, and I authorize release of all information contained on this claim to Paragon Benefits, Inc. and my Employer.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION B: Patient Information

Patient's Name (Last, First, MI)	Relationship to Employee	Gender	Itemized Medical Bills	Total \$ Amount for Patient
	<input type="radio"/> Self <input type="radio"/> Dependent <input type="radio"/> Spouse <input type="radio"/> Other			\$
	<input type="radio"/> Self <input type="radio"/> Dependent <input type="radio"/> Spouse <input type="radio"/> Other			\$
	<input type="radio"/> Self <input type="radio"/> Dependent <input type="radio"/> Spouse <input type="radio"/> Other			\$
	<input type="radio"/> Self <input type="radio"/> Dependent <input type="radio"/> Spouse <input type="radio"/> Other			\$

TOTAL FOR ALL MEDICAL: \_\_\_\_\_ \$ \_\_\_\_\_

### SECTION C: Prescription Information

**IMPORTANT:** Submit either prescription receipts/labels with this claim form or a patient history print-out from your pharmacy. Claims missing any of the following information may be returned or payment may be denied. Also, attach itemized bills from doctor's offices who do not file insurance claims.

**Pharmacy Claims: Pharmacy Name/Address; Date Filled; Drug Name and Strength; Rx Number; Quantity; Price**

*Note: Altered receipts require signature.*

### SECTION D: Other Coverage Information (Specific coordination of benefits form available upon request.)

Is coverage for this claim provided by any other group insurance, federal program, or any other insurance program?  Yes  No

Name of other carrier: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Have these claims been processed by the other carrier?  Yes  No

### SECTION E: Reason For Claim Submission or Special Notes:

\_\_\_\_\_

Mail the completed claim to:  
**Paragon Benefits**  
 P.O. Box 12288 Columbus, GA 31917  
 Phone: 1.800.277.9218

Fax: 1.706.256.4089  
 Email: submitclaims@paragonbenefits.com