



# UNIFORM MEDICAL PLAN Prescription Drug Claim Form

Please submit claim forms to:

Washington State Rx Services

Attn: Pharmacy

P.O. Box 40168

Portland, OR 97240-0168

888-361-1611

www.ump.hca.wa.gov

Subscriber ID Number **W** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Subscriber Name (Please Print) \_\_\_\_\_  
First Middle Last  
Street City State ZIP Code

Prescriptions were dispensed to:

Patient Name \_\_\_\_\_  
First Middle Last

Patient Birth Date \_\_\_\_\_  Male  Female Relationship to Subscriber  Self  Spouse  Child  
(check one)

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

Does this patient have prescription coverage under any other group insurance plan?  Yes  No

If yes, provide the name of the insurance company and other employer. \_\_\_\_\_  
Name of Insurance Company

Street City State ZIP Code

Note: Use a separate claim form for each covered patient of the family. 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.

Signature of Patient (or Parent if a Minor) \_\_\_\_\_

Please attach a receipt that includes the following information, or have your pharmacist complete and sign the sections below.  
Important: If this claim is for a compounded medication, please have your pharmacist complete both pages of this form.

Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx Directions	Days Supply
Medication Name, Dosage, Form & Strength				Physician's name and DEA/NPI #	
NDC Number (11-digit)		Rx Price Including Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No	
Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx Directions	Days Supply
Medication Name, Dosage, Form & Strength				Physician's name and DEA/NPI #	
NDC Number (11-digit)		Rx Price Including Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No	
Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx Directions	Days Supply
Medication Name, Dosage, Form & Strength				Physician's name and DEA/NPI #	
NDC Number (11-digit)		Rx Price Including Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No	

### PHARMACY INFORMATION

Pharmacy Name	Ten-digit NPI Number Required	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Street Address	<b>Note: Benefits are payable directly to the covered individual and any assignment of these benefits is void.</b>	
City State ZIP Code	Pharmacist's Signature _____	Date _____
	Pharmacy telephone number	fax number



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## Prescription Drug Claim Form *(continued)* for Compounded Prescriptions Only

If your prescription is for a compounded drug, ask your pharmacist to fill out this form. Mail this form along with Prescription Drug Claim Form (page 1) and a receipt.

### For Pharmacy use only

- › Enter the NDC number of the most expensive ingredient of the legend drug used.
- › Indicate the drug ingredient(s) and quantity.
- › Indicate the metric quantity dispensed in number of tablets, grams or milliliters for liquids, creams, ointments, and injectables.
- › Indicate the amount paid for the prescriptions by the patient.

Compounded Prescription Chart .....			
NDC#	Drug Ingredient	Quantity	Charge
Note: If purchased in a foreign country, the currency must be converted into US dollars.		<b>TOTAL</b>	\$ <span style="border: 1px solid black; display: inline-block; width: 80px; height: 20px; vertical-align: middle;"></span>

**IMPORTANT:** The original Pharmacy prescription label/receipt (including the required drug information) must accompany this claim form. Please do not highlight receipts or items on this form as this will not appear on scanned images and may delay processing of your claim. Pharmacy receipts will not be returned, it is recommended that you make copies for your own records.