Direct Reimbursement Claim Form

Please read carefully before completing this form.
Please tape pharmacy receipts to claim form. Payment will be delayed unless information is completed.

Mail completed forms to:

Quality Health Plans of New York
Attn: Pharmacy Department
6916 W. Linebaugh Ave., Suite 101
Tampa, FL 33625

Cardholder Information

Cardholder Last Name | Cardholder First Name | Cardholder Date of Birth

Cardholder ID Number | Cardholder Group Number | Other Insurance (if any) | Cardholder Phone Number

Cardholder Street Address | City | State/Prov. | Zip Code

Pharmacy Information

Pharmacy Name | NABP Number

Pharmacy Street Address | City | State/Prov. | Zip Code

Claim Information (1)

Date of Service | Rx Number | Name, Strength and Form of Medication | Amount Paid ($)

NDC (National Drug Code) | Quantity | Day Supply | Physician's Name | Physician's DEA

Claim Information (2)

Date of Service | Rx Number | Name, Strength and Form of Medication | Amount Paid ($)

NDC (National Drug Code) | Quantity | Day Supply | Physician's Name | Physician's DEA

Claim Information (3)

Date of Service | Rx Number | Name, Strength and Form of Medication | Amount Paid ($)

NDC (National Drug Code) | Quantity | Day Supply | Physician's Name | Physician's DEA

Claim Information (4)

Date of Service | Rx Number | Name, Strength and Form of Medication | Amount Paid ($)

NDC (National Drug Code) | Quantity | Day Supply | Physician's Name | Physician's DEA

I certify that patient information entered on this form is correct and the named patient is eligible for the benefits claimed and has received the medication described. I also certify that this medication received is not for treatment of an on-the-job injury. I authorize ***Quality Health Plans of New York*** to release all information pertaining to this claim to the Pharmacy Benefit Manager. I understand that payment of this claim will be made to the cardholder unless otherwise specified within this document. I also certify that I personally have incurred this expense and am entitled to reimbursement.

Any person who knowingly and with intent to defraud any insurance company 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Patient or Guardian or Legal Representative: **X**_____

SIGNATURE REQUIRED FOR REIMBURSEMENT

QualityHealthPlans of New York

Direct Reimbursement Claim Form

Please Affix Pharmacy Receipt(s) Below

Attach Pharmacy Receipt Here (1)	Attach Pharmacy Receipt Here (2)
Attach Pharmacy Receipt Here (3)	Attach Pharmacy Receipt Here (4)

Before you mail this form, be sure to:

- **Fill out the form completely**
- **Sign your claim form**
- **Attach all your pharmacy receipts**

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You can obtain additional forms by calling our Customer Service Department at **877-233-7058**
or visiting our website **www.qualityhealthplansny.com**