



Prescription Paper Claim Form



Please complete and return this form when you have purchased a covered prescription drug at retail cost and are seeking reimbursement. Submit this form with the original prescription receipt(s). **Cash Register, cancelled checks, and credit card receipts are NOT acceptable as proof of purchase.** This will only delay payment as they do not contain the necessary information needed to process a claim. Reimbursement is not guaranteed. Claims will be subject to limitations and other provision of the plan benefit.

Patient Information (one form per patient)			
Cardholder Name:	Cardholder DOB:	Cardholder ID #	Cardholder Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:	City:	State: Zip Code:	Primary Phone #: Secondary Phone #:
Member Name (if other than cardholder)	Member DOB:	Relationship to Cardholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Member Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Health Plan (Insurance) Name:	Prescribing Physician's Name:	Physician's Phone #:	Drug Name:
Reason for Request (at least one must be checked)			
<input type="checkbox"/> Out of Area emergency medication <input type="checkbox"/> Non-emergency medication/vacation request <input type="checkbox"/> Identification card not available or member not found in the pharmacy system			
<input type="checkbox"/> Compound <input type="checkbox"/> Coordination of Benefit (From Primary Insurance) <input type="checkbox"/> Other _____ in the			
<p>I certify that the information on this claim form is correct and authorize release of all information to Ventegra. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan, i.e. workman's comp. I understand that drug(s) listed below is not for treatment of an on-the-job injury or covered by any other insurance plan.</p> <p>Please remit payment and/or explanation of benefits to: (check one)</p> <input type="checkbox"/> Cardholder (Primary Subscriber) <input type="checkbox"/> Dependent			
Signature:		Date:	

Ventegra Customer Care Team: 877-867-0943
Open Monday – Friday: 5:00 AM/PST to 9:00 PM/PST
Saturday: 7:00 AM to 7:00 PM/PST, Sunday: 7:30 AM/PST to 4:00 PM/PST for your convenience

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a member of Ventegra, Inc. will receive the "lesser" of usual and customary "U&C" charge of this provider, or the contracted price of the product. Reimbursement may be lower than the amount submitted by your pharmacy provider. Ventegra network pharmacies are contracted to provide services for your pharmacy benefit plan on a fixed reimbursement schedule and this reimbursement reflects these rates. If this reimbursement has been reduced, please see your pharmacy. They are terrific allies in building cost containment programs for our health plan.

Please verify that the Prescription receipt contains the following information about the prescription:

<input type="checkbox"/> Pharmacy Name	<input type="checkbox"/> Physician Name	<input type="checkbox"/> Name of Drug Dispensed	<input type="checkbox"/> Days Supply
<input type="checkbox"/> Pharmacy Address	<input type="checkbox"/> Patient Name	<input type="checkbox"/> NDC Number of the drug	<input type="checkbox"/> Quantity Dispensed

<input type="checkbox"/> Pharmacy Phone Number	<input type="checkbox"/> Date of Service	<input type="checkbox"/> Prescription Number	<input type="checkbox"/> Amount Paid
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Please mail label receipts and this complete form to:

Ventegra, Inc.
10400 Overland Road
Box #353
Boise, ID 83709

The Ventegra staff is available to assist members and pharmacies having difficulty submitting claims for any reason. Our pharmacy network is able to process your claims within a day window.