PERFORMRx℠ | FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

PRESCRIPTION CLAIM FORM

Member Information

Member Name (Last, First, Middle Initial)

Date of Birth	**Gender (M or F)**	**Member ID Number**

Members Home Address and Daytime Phone Number

Member's Signature and Date

I certify that all the information provided is correct and that the prescriptions submitted are for myself as an eligible member. I certify that I have received this medication (s) and I authorize release of all information contained on this claim to PerformRx.

Prescription Information

Number of Prescriptions	**Total Dollar Amount Spent**

Name, Address and Phone Number of Prescribing Physician(s)

Reason for the Request (be specific)

Please read the reverse side for instructions.

Please read the following instructions carefully and complete form on the reverse side.

Member Information

1. Print Member's Name (Last, First, Middle Initial)
2. Print Member's Date of Birth
3. Select correct letter to indicate the Member's gender (M-male, F-female)
4. Print the Member's ID number (located on the Member's ID card)
5. Print Member's address and telephone number.

Important: Claim Form must be signed.
Unsigned forms cannot be processed and will be returned.

Prescription Information

1. Indicate the number of prescriptions attached.
2. Provide the total dollar amount paid for prescriptions.
3. Provide Prescribing Physicians name, address and phone number.
4. Indicate reason you are submitting the claim(s).
5. Attach valid proof of prescription purchase. Include one of the following:
   a) Patient history printout from the pharmacy, **signed** by the pharmacist;

   OR

   b) Prescription receipt which includes all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days supply
- Price
- Member's Name

Note: Claims missing any of the information above may be returned or payment denied.

You can submit multiple receipts with this claim form.
Please feel free to attach additional paper, if necessary.

Reason for the Request

This section is to be used to explain the reason for the reimbursement request.

Please return this claim to: PerformRx/ First Choice VIP Care Plus
P.O. Box 516
Essington, PA 19029

If you have any questions, please contact:
First Choice VIP Care Plus Member Services
Call 1-888-978-0862
TTY/TDD Users Call 711
7 day a week, 8 a.m. to 8 p.m.

Rev. 6/13/17

First Choice VIP Care Plus is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios al Miembro de First Choice VIP Care Plus al 1-888-978-0862 (TTY 711), los siete días de la semana, de 8 a.m. a 8 p.m. La llamada es gratuita.

You can get this information for free in other formats, such as large print, braille, or audio. Call 1-888-978-0862 (TTY: 711), 8 a.m. to 8 p.m., 7 days a week. The call is free.