THE ODS COMPANIES

601 S.W. Second Avenue
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www.odscompanies.com

PRESCRIPTION DRUG CLAIM FORM

Group # _____ Certificate/ Subscriber ID Number | | | | | | | | | | – | |

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 (check one) Self _____ Spouse _____ Child _____

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

Is this medication covered 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

Have you been treated within the past 24 months for the same condition for which any of these drugs have been prescribed? Yes _____ No _____

If Yes, indicate date when first treated. _____ If yes, indicate the condition being treated. _____

Note: Use a separate claim form for each covered member 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 _____
Patient (or Parent if a Minor)

PLEASE ASK YOUR PHARMACIST TO COMPLETE THE REMAINING PORTION; WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION.

Rx Number	Date Filled	Check One	Quantity	Rx Directions	Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number	
Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions	Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number	
Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions	Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number	
Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions	Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number	
Rx Number	Date Filled	Check One ☐ New ☐ Refill	Quantity	Rx Directions	Days Supply	Rx Price Incl. Tax
Medication Name, Dosage, Form & Strength			Mfg Name	M.D. DEA	NDC Number	

Place Pharmacy Label Here or Enter

Pharmacy Name

Street Address

City State ZIP Code

Seven digit NABP Number Required | | | | | | | |

Note: Benefits are payable directly to the covered individual and any assignment of these benefits are void.

Pharmacist's Signature _____

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