PERFORMRx

AmeriHealth Caritas VIP Care

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/AmeriHealth Caritas VIP Care
Attention: Direct Member Reimbursement
P.O. Box 516
Essington, PA 19029

If you have any questions, please contact:
AmeriHealth Caritas VIP Care
Call 1(866)773-7991
TTY/TDD Users Call 711
24 hours a day, seven days a week