



Prescription drug claim form

Please read carefully the following instructions before completing this form.

Claim forms with missing information cannot be processed and will be returned to the sender.

Patient and subscriber information (to be completed by the member)

1. Complete all information in Part 1. The member or subscriber ID number is located on your health plan ID card.
2. A claim must be submitted to EOCCO within 90 days of the date the expense was incurred. Under no circumstances will claims submitted later than one year from that date be considered valid, except in the case of legal incapacity.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications. Payment and related correspondence will be sent to the primary subscriber unless you have made arrangements with Moda Health to send to an alternate address.

Pharmacy information

1. If required information is not available on the receipt, ask your pharmacy representative to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records

Prescription information

1. Submit detailed prescription receipts or labels that contain the requested information (shown below), or have your pharmacy representative complete Part 2 and Part 3. If you do not submit a detailed prescription receipt for your prescription(s), a pharmacy representative signature is required.
2. Include a copy of your pharmacy receipt(s). Photocopy receipts and submit with the claim form. *Note: please do not staple receipts or other documentation to the claim form.*
3. If you have more than one claim, submit a separate Part 2 for each medication or use the multiple prescription alternative form.
4. Receipts for the administration of vaccines require completion of Part 2 and Part 3. A pharmacy representative signature is required.
5. Compounded medications require a separate Compound Claim Form.
6. Receipts for medication purchased outside the U.S. must be translated into English, including conversion of currency conversion into U.S. dollars. You also must include the required prescription and pharmacy information as indicated below.

Section 1 ▶ Patient and subscriber information (to be completed by the member)

Patient last name*		Patient first name*		Patient M.I.	
Patient date of birth (mm/dd/yyyy)*		Patient address			
Relationship to primary subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent		City		State	ZIP code
Subscriber last name*		Subscriber first name*		Subscriber M.I.	
Subscriber ID no.*	Group no.	Group/employer name		Subscriber date of birth (mm/dd/yyyy)*	
Does this member have prescription coverage under any other group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide the name of the health plan and other employer			
<input type="checkbox"/> 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.					
Member signature* X		Phone no.		Date (mm/dd/yyyy)	

Indicate reasons for filing a claim(s) (select one)*:

- Coordination of benefits – claims must be submitted with pharmacy receipt(s) identifying copays paid and an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary health plan payment)
- Medicare is primary prescription coverage
- Discount card was used
- Health plan, health coverage information or health plan ID card was not available at the time of purchase
- Pharmacy not participating in network
- Pharmacy unable to process claim electronically
- Emergency – please explain _____
- Worker’s compensation
- Prescription purchased outside the U.S. Please see claim instructions on previous page.
- Other _____

Submission of claims does not guarantee reimbursement.

Section 2 > Pharmacy information

Affix pharmacy label here or enter the required information. If the information below is not on the receipt(s) you submit, ask your pharmacy representative to complete and sign.

Pharmacy name*	Pharmacy phone no.	Pharmacy NPI or NABP*	
Pharmacy address	City	State	ZIP Code
Pharmacy representative signature* X		Date (mm/dd/yyyy)*	

Section 3 > Prescription information

If the information below is not on the receipt(s) you submit, ask your pharmacy representative to complete. Each pharmacy may have a unique label format but please use the sample as a guide to locate the required information.

Anytime Pharmacy #1234 123 Any Street Home Town, US 12345-6789 RX 1234567	(509) 555-1234 6 NPI: 1234567890 7 Date Filled: 1/1/2009
1 DOE, JANE 456 Home Road Home Town, US 12345	8 DOB: 01/01/1900 (509) 555-5678
2 Amoxicillin 500 mg capsules (Teva) DAW: 0	4 QTY: 45 9 Days Supply: 30
3 NDC #00000-1111-22	5 U&C: 200.00 10 COPAY: 20.00

- 1 Patient name
- 2 Medication name and strength
- 3 National drug code (NDC)
- 4 Quantity
- 5 Usual and customary price (Rx price)
- 6 Provider NPI or NABP number
- 7 Date filled
- 8 Patient date of birth
- 9 Day supply
- 10 Copay

Rx no.	Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name	Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*
Vaccine admin fee (if applicable)			

Is this a compound? Yes No

If yes, please identify NDC ingredients and quantity amounts on the Compound Claim Form.

Rx no.		Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

Rx no.		Medication name*	Medication strength*	<input type="checkbox"/> New prescription <input type="checkbox"/> Refill
Physician name		Physician NPI number	Date filled (mm/dd/yyyy)*	National drug code (11-digit)*
Quantity*	Day supply*	Rx price*	Copay*	Vaccine admin fee (if applicable)

* Indicates required information

Ready to submit? Mail this form to EOCCO, P.O. Box 40168, Portland, OR 97240-0168
or fax to 800-207-8235, ATTN: Rx Claims Department

Questions? Call EOCCO Pharmacy Customer Service at 888-474-8539.

Nondiscrimination notice



We follow state and federal civil rights laws. We cannot treat people unfairly in any of our services or programs because of a person's age, color, disability, gender identity, marital status, national origin, race, religion, sex or sexual orientation.

Everyone has the right to know about our programs and services. All members have a right to use our programs and services. We give free help when you need it. Some examples of free help we can give are:

- Sign language interpreters
- Spoken language interpreters for other languages
- Written material in other languages
- Braille
- Large print
- Audio and other formats

If you need any of the above, call Customer Service at:

888-788-9821 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

EOCCO
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Nick Gross coordinates our nondiscrimination work:

Nick Gross,
Chief Compliance Office
601 SW Second Ave.
Portland, OR 97204
503-952-5033
compliance@eooco.com

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意: 如果您說中文, 可得到免費語言幫助服務。請致電1-877-605-3229 (聾啞人專用: 711)

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

بولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو امانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں (711) 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با تماس بگیرید. (TTY: 711) 1-877-605-3229

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意: 日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229 (TTY、テレタイプライターをご利用の方は711)までお電話ください。

အကူအညီ: ဤတမ်း (မြန်မာစကားပြော ဗမာအင်္ဂလိပ် အသံပြော) ဝါးဝါး ဝါး တံ တံ မြန်မာစကားပြော မှာ ဝါး ဝါး မြန်မာစကားပြော ဝါး ဝါး 1-877-605-3229 (TTY: 711) ပါ အသံ အသံ

ໄປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ: បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณจะสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)