



Prescription Drug Claim Form

All fields required. Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for Approval/Denial status of this request.

Part one:

Subscriber Information:

1. Complete ALL information. Your ID Number can be located on your member ID card.
2. Please submit a separate form for each patient for which you purchased medications.

| | | | |
|---|--|---|------------------|
| ID Number: | | | |
| Member's First Name: | | Member's Last Name: | |
| Address: | | City: | State: Zip Code: |
| Patient's First Name: | | Patient's Last Name | |
| Patient's Date of Birth: | | Patient's Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent | |
| Signature of Patient, Guardian or Legal Representative: | | | Date Signed: |

Part Two:

Coordination of Benefits (COB):

| | |
|---|------------------|
| Does Patient have other Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No | ID Number: |
| Name of Carrier: | Carrier Address: |

Part Three:

Pharmacy Information:

1. Complete ALL information
2. Please submit a separate form for each pharmacy from which you purchased medications.

| | | | |
|-----------------|--|---------------|------------------|
| Pharmacy Name: | | Phone Number: | |
| Street Address: | | City: | State: Zip Code: |

Part Four:

Prescription Information:

Include original pharmacy receipt(s) or pharmacy printout(s); Cash Register Receipt(s) without pharmacy detail will not be accepted.

| Date Filled: | Medication: | Prescribing Physician Full Name: | Prescription Cost |
|--------------|-------------|----------------------------------|-------------------|
| | | | |
| | | | |
| | | | |



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Claims Receipts: Tape your receipts to page 3 of this claim form. Your prescription claim receipts must accompany this form. The receipts must contain the following information:

- Date prescription was filled
- Prescription Number
- Doctors name
- Pharmacy name
- Drug name and strength
- Quantity
- Amount paid

Please note, as of 01/01/2018, PreferredOne may process paper claims at the pharmacy contracted dollar amount, not the submitted (member paid) dollar amount.

Return this completed form with receipt(s) to:

PreferredOne Insurance Company
Pharmacy Claims
6105 Golden Hills Drive
Golden Valley, MN 55416- 1023



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Tape Receipts here: