OPUSHealth a cegedim business

1324 Motor Parkway – Suite 105 – Islandia - NY - 11749 www.opushealth.com Tel: 1-800-364-4767

Please complete this form and submit with all required information and attachments to be considered for reimbursement. *Do not submit claims for any prescription covered under Medicare, Medicaid, CHAMPUS, TRICARE or any state or federally funded programs, nor for any amount covered by insurance, FSA or HSA - none of which are eligible for payment.*

Patient Information

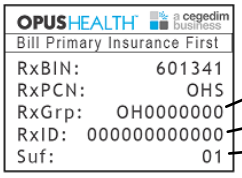
Name (Last, First)**:** _____, _____ **Address** (Street)**:** _____

Apt./Suite No. _____ **City:** _____ **State:** ☐☐ **Zip:** ☐☐☐☐☐-☐☐☐☐

Email:_____**@**_____ **Phone:** ( ) _____ - _____ **Fax: ( )** _____ - _____

(Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)

Please refer to the OPUS Health box, found on your card or printed offer, for the required information. It will look similar to the example shown (right).



RxGrp#: O H ☐☐☐☐☐☐☐☐

RxID#: ☐☐☐☐☐☐☐☐☐☐☐☐

Suf: ☐☐

[ ] Check this box if you are including a copy of your copay card or printed offer with this claim request to ensure accuracy.

Insurance Information

Do you have Health Insurance: [ ]No [ ]Yes and my insurer for prescription benefits is: _____.

My insurance covered: [ ]This entire prescription [ ]None of this prescription [ ]All except copay of: $ _____.

This prescription was filled at [ ]a retail pharmacy store, [ ]through mail order or specialty pharmacy (EOB required)*

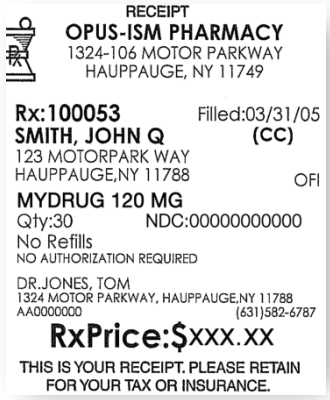
***Specialty/Mail order claims require a copy of the Explanation of Benefits for this prescription from your insurance provider.**

Pharmacy Receipt

Mail this completed form along with the following items to the following address:

OPUS Health, Attn: Card Processing Department
1324 Motor Parkway, Suite 105, Hauppauge, NY 11749

1. The original pharmacy receipt received from your pharmacy with your Rx, (Cash register receipts are NOT acceptable) which must include the following information (see sample receipt, right):
   - ✓ Patient name and address
   - ✓ Pharmacy name, address and phone
   - ✓ Doctor or health care provider name, address and phone
   - ✓ Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity
   - ✓ Overall prescription price and Copay amount/out of pocket expense paid
2. Copy of your EOB (if required as stated in Insurance Information section above)


RECEIPT
OPUS-ISM PHARMACY
1324-106 MOTOR PARKWAY
HAUPPAUGE, NY 11749

Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788
OFI
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED

DR.JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE,NY 11788
AA0000000 (631)582-6787

RxPrice:$XXX.XX

THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

Certification Statement

"I, _____, certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, CHAMPUS or any other government (state or federally funded) program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law."

Claimant/Patient/Legal Guardian Signature: _____ Date_____

Please allow 3 – 5 weeks for processing. This form can be used for multiple submissions.
For assistance completing this form, contact OPUS Health at 1-800-364-4767 and select the Patients option.

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