



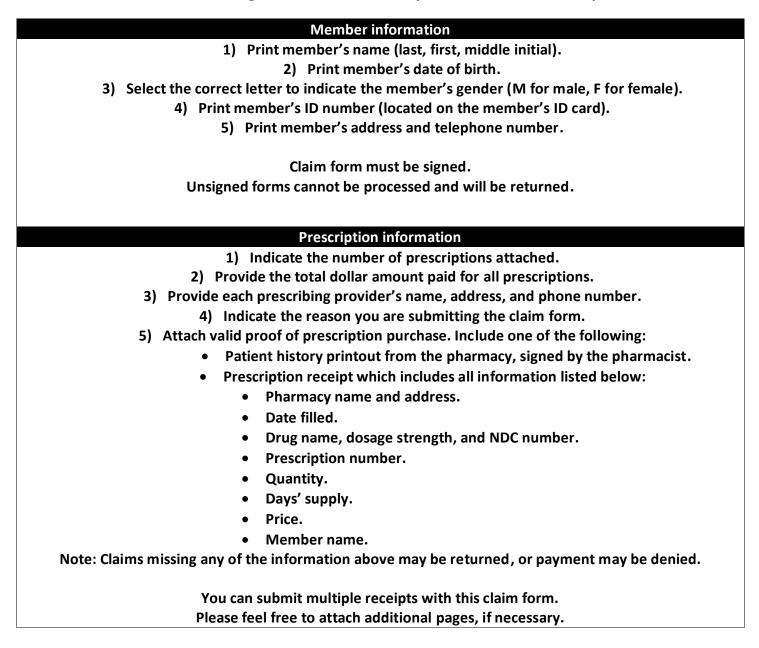
Next Generation Pharmacy Benefits

PRESCRIPTION CLAIM FORM

| Member information | | |
|--|--------------------------------|---------------------------|
| | Member name (last, first, midd | lle initial) |
| | • • • | · · · · |
| | | |
| Date of birth | Gender (M or F) | Member ID number |
| | | |
| | | |
| Member add | ress | Phone number |
| | | |
| | | |
| | | |
| | | |
| | | |
| | Member signature and d | ate |
| | | |
| I certify that all the information provided on this form is correct and that the prescriptions submitted are | | |
| for myself as an eligible member. I certify that I have received this medication, and I authorize release of all information contained on this claim form to PerformRx SM . | | |
| | Prescription informatio | |
| Number of process | | |
| Number of prescr | riptions | Total dollar amount spent |
| Number of prescr | riptions | Total dollar amount spent |
| Number of prescr | riptions | Total dollar amount spent |
| | dress, and phone number of pr | |
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| Name, ad | dress, and phone number of pr | escribing providers |

Please read the following page for instructions.

Please read the following instructions carefully and use them to complete the form.



Reason for the request

Use this section to explain why you are requesting reimbursement.

Please return this claim to: AmeriHealth Caritas VIP Care Plus Attention: Direct Member Reimbursement 200 Stevens Drive, Fourth Floor Philadelphia, PA 19113

If you have any questions, please contact: AmeriHealth Caritas VIP Care Plus (Medicare-Medicaid Plan) 1-888-667-0318 (TTY 711) Seven days a week, 8 a.m. to 8 p.m.