Neighborhood INTEGRITY (Medicare-Medicaid Plan)

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 Provider(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 Provider's 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:

Neighborhood INTEGRITY
Attn: Member Services
910 Douglas Pike
Smithfield, RI 02917

If you have any questions, please contact:
Neighborhood INTEGRITY Member Services
Call 1-844-812-6896
TTY/TDD Users Call 711

Our hours of operation are 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Neighborhood Health Plan of Rhode Island is a health plan that contracts with both Medicare and Rhode Island Medicaid to provide the benefits of both programs to enrollees.

You can get this information for free in other languages. Please call our Member Services at 1-844-812-6896 (TTY 711), 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

Esta información está disponible de forma gratuita en otros idiomas. Por favor llame a nuestro Departamento de Servicios para Miembros al 1-844-812-6896 (TTY 711) de 8 am a 8 pm, lunes-viernes; sábados de 8 am a 12 pm. Los sábados por la tarde, domingos y días festivos federales, se le pedirá que deje un mensaje. Su llamada será devuelta dentro del siguiente día laborable. La llamada es gratuita.

Estas informações estão disponíveis gratuitamente noutros idiomas. Por favor telefone para os Serviços dos Membros em 1-844-812-6896 (TTY 711), das 8 às 20 horas, de Segunda a Sexta-feira; e das 8 às 12 (meio-dia) aos Sábados. Nos Sábados à tarde, Domingos e feriados federais, poderá ser-lhe pedido que deixe uma mensagem. A sua chamada será respondida no próximo dia útil. Esta chamada é grátis.