IQVIA, Inc. / 77 Corporate Dr. / Bridgewater, NJ 08807 / Attn: Claims Processing Dept. PTR.patientsavings.com Tel: 1-888-636-1337

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): _____ , _____ **Date of Birth:** ____ / ____ / ____

Address (Street): _____ Apt./Suite No. _____

City: _____ **State:** _____ **Zip:** _____ - _____

Email: _____@_____ Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.

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

Medication Information

Please refer to the IQVIA box, found on your card or printed offer, for the required information. Example below.

RxBIN: 601341
RxPCN: OHCP
RxGrp: OHXXXXXXX
RxID: 000000000000
Suf: 01

RxGrp#: O H
RxID#:
Suf:

Name of drug you are submitting a claim for: _____

[ ] Check this box if you are including a copy of your copay card or printed offer 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

Pharmacy Receipt

Mail this completed form along with the following items to: **Attn: Claims Processing Department, IQVIA, Inc., 77 Corporate Dr., Bridgewater, New Jersey 08807** or submit your claim online at PTR.patientsavings.com

Failure to include any of the following will result in claim rejection:

1. The **original pharmacy receipt** received from your pharmacy with your Rx *(see sample receipt at the right)* which must include the following information:
   - Patient name and address
   - Pharmacy name, address, and phone number
   - Doctor or health care provider name, address, and phone number
   - Prescription # (Rx #), fill date, drug name, strength, NDC #, and quantity
   - Overall prescription price and copay amount/out of pocket expense paid
2. The **cash register receipt or Explanation of Benefit (EOB)** with the amount paid for this prescription clearly identified.
3. A **copy of your primary insurance card**, including both front and back of the card


RECEIPT
ANY PHARMACY, INC
100 Main St.
Anytown, NY 12345
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 by any government program, without limitation, including, Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS or any state patient or pharmaceutical assistance program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

In support of my claim for reimbursement of my pharmacy expenses, I authorize the Company and its agents to contact my pharmacy to disclose information about the pharmacy claim for which I am seeking reimbursement.

A copy of this authorization is as valid as the original, and this authorization will be valid even if I sign it electronically.

Please allow 4-6 days for processing. This form can be used for multiple submissions.
For assistance completing this form, contact IQVIA at 1-888-636-1337 and select the "Patient" option.