PERFORMRx℠
Next Generation Pharmacy Benefits

AmeriHealth Caritas
VIP Care Plus

PRESCRIPTION CLAIM FORM

Member information		
Member name (last, first, middle initial)		
Date of birth	Gender (M or F)	Member ID number
Member address		Phone number
Member signature and date		
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℠.		
Prescription information		
Number of prescriptions		Total dollar amount spent
Name, address, and phone number of prescribing providers		
Explain why you are sending this request. Please provide as much detail as possible.		

Please read the following page for instructions.

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

Member information

1) Print member's name (last, first, middle initial).
2) Print member's date of birth.
3) Select the correct letter to indicate the member's gender (M for male, F for female).
4) Print member's ID number (located on the member's ID card).
5) Print member's address and telephone number.

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 all prescriptions.
3) Provide each prescribing provider's name, address, and phone number.
4) Indicate the reason you are submitting the claim form.
5) Attach valid proof of prescription purchase. Include one of the following:
   - Patient history printout from the pharmacy, signed by the pharmacist.
   - Prescription receipt which includes all information listed below:
     - Pharmacy name and address.
     - Date filled.
     - Drug name, dosage strength, and NDC number.
     - Prescription number.
     - Quantity.
     - Days' supply.
     - Price.
     - Member name.

Note: Claims missing any of the information above may be returned, or payment may be denied.

You can submit multiple receipts with this claim form.
Please feel free to attach additional pages, if necessary.

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.**