Prescription Drug Claim Form

**CLAIMS MUST BE FILLED WITHIN ONE (1) YEAR OF PURCHASE DATE.

Please mail, fax or email this form with your receipt(s) to:

EVO First
10645 N Tatum Blvd, Suite 200 - 203
Phoenix, AZ 85028

Phone: 844-386-0001
Fax: 844-386-0001
Email: pa@evofirst.com

Part 1

** Indicates required information*

Primary Member/Subscriber ID number*	Group Number		
Group/Employer Name	Primary Subscriber		Subscriber Date of Birth (mm/dd/yyyy)* / /
Patient Name (First, Middle, Last)*	Male ☐ Female ☐	Date of Birth (mm/dd/yyyy)*	Relationship to primary subscriber Self ☐ Spouse ☐ Dependent ☐ Domestic Partner ☐
Address (Street, City, State, Zip Code)	Email Address*		
I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.			
Member Signature*	Telephone Number ( )		Date / /

Indicate reason for filing a claims(s), select one:

- ☐ Health plan, insurance information, or insurance card was not available at the time of purchase
- ☐ Pharmacy unable to process claim electronically
- ☐ Discount card was used
- ☐ Pharmacy not participating in network
- ☐ Prescription purchased outside the U.S.
- ☐ Coordination of benefits
- ☐ Medicare is primary prescription coverage
- ☐ Workers' compensation
- ☐ Other _____

Claims must be submitted with pharmacy receipt(s) identifying copays paid and an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing insurance payment).

****Submission of claims does not guarantee reimbursement****

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Part 2

Affix pharmacy label here or enter the required information.

Pharmacy Name*			Pharmacy Phone Number
Street Address			Pharmacy NABP or NPI*
City	State	Zip Code	

Part 3a

Rx Number	Date Filled / /	New ☐ Refill ☐ (Check one)	Quantity*	Day Supply*	National Drug Code (NDC) 11-Digits*
Medication Name and Strength*	Is this a Compound? Yes ☐ No ☐		Rx Name $	Vaccine Admin Fee $	Copay $
Physician Name	NPI Name				

Part 3b

Rx Number	Date Filled / /	New ☐ Refill ☐ (Check one)	Quantity*	Day Supply*	National Drug Code (NDC) 11-Digits*
Medication Name and Strength*	Is this a Compound? Yes ☐ No ☐		Rx Name $	Vaccine Admin Fee $	Copay $
Physician Name	NPI Name				

Part 3c

Rx Number	Date Filled / /	New ☐ Refill ☐ (Check one)	Quantity*	Day Supply*	National Drug Code (NDC) 11-Digits*
Medication Name and Strength*	Is this a Compound? Yes ☐ No ☐		Rx Name $	Vaccine Admin Fee $	Copay $
Physician Name	NPI Name				