Print Form

UHA
HEALTH INSURANCE

PRESCRIPTION DRUG CLAIM FORM

700 Bishop Street, Suite 300, Honolulu, HI 96813

For member reimbursement only. Use Separate Claim for Each Patient.
Mail completed Drug Claim Form to UHA at the above address.
Claim must be filed within 90 days of date dispensed. No payment will be made for late claims

PART A	***Subscriber: Please complete all Part A areas***	
Subscriber's First Name, Middle Initial, Last Name	Patient's Member ID	
Patient's First Name, Middle Initial, Last Name	Male ☐ Female ☐	Birthdate (MM/DD/YYYY) _____/_____/_____
Prescribed by (Name of Physician)		

Is treatment result of occupational illness or injury? ☐ Yes ☐ No

Is treatment result of auto accident? ☐ Yes ☐ No

Other accident? ☐ Yes ☐ No

Is patient covered by another drug plan? ☐ Yes Other plan name _____ ☐ No

If prescription(s) was purchased by Mail Order, complete Part A and attach invoice with prescription information, charge and patient copay amounts paid.

I hereby authorize any pharmacy or physician to disclose to UHA information on the drug(s) and quantity of the prescription(s) named hereon. I also certify that the prescription(s) being submitted for reimbursement has been received.

_____ _____
Signature of Subscriber Date

PART B ***Provider: Please complete all Part B areas***

Rx No.	National Drug Code (N.D.C.)	DAW	Quantity	Days Supply	Date Dispensed Mo.	Day	Year	"X" if Refill	Charge	Patient Co-pay	Balance
1											
2											
3											
4											
5											
								TOTAL			

I certify that the above Part B information is true and correct.

_____ _____
Signature of Provider Date

_____ _____
Provider Name and Address Provider NABP No.