UC SHIP Prescription Paper Claim Form

1. Complete this from
2. Include all receipts*
3. Mail to: Ventegra, LLC
   450 N. Brand Blvd. Ste. 600
   Glendale, CA 91203

	THIS FORM TO BE COMPLETED BY STUDENT			
STUDENT NAME:	**MEMBER ID NUMBER**(can be found on your ID card)**:**		**NAME OF CAMPUS/PLAN:**	
STREET ADDRESS:	**STUDENT BIRTH DATE:**		**GROUP#**(can be found on your ID card)**:**	
CITY:	**STATE**	**ZIP**	**PHONE NUMBER:** **HOME:** **WORK:** **CELL:**	
PATIENT NAME: (IF OTHER THAN STUDENT)	**GENDER:** ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F	**RELATIONSHIP TO STUDENT:** _____ _____ _____ _____	**PATIENT BIRTH DATE:** -----/-----/------ -----/-----/------ -----/-----/------ -----/-----/------	**CLAIM(S) FILLED AS:** _____ _____ _____ _____

I certify that the information on this claim form is correct and authorize release of all information to Ventegra. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan, i.e. workman's comp. I understand that drug(s) listed below is not for treatment of an on-the-job injury or covered by any other insurance plan.

Signature: _____ **Date:** _____

VENTEGRA CUSTOMER CARE TEAM 877-867-0943
OPEN M-F 7:00AM – 9:00PM & SAT 7:00AM – 7:00PM FOR YOUR CONVENIENCE

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a member of Ventegra, LLC, will receive the "lesser" of usual and customary "U&C" charge of this provider, or the contracted price of the product. Reimbursement may be lower than the amount submitted by your pharmacy provider. Ventegra network pharmacies are contracted to provide services for your ăúdzŘŜyű KŜI·tűK LJfI·y˙on a fixed reimbursement schedule and this reimbursement reflects these rates. If this reimbursement has been reduced, please see your pharmacy. They are terrific allies in building cost containment programs for our ăúdzŘŜyű KŜI·tűK LJfI·y˙.

INSTRUCTIONS

***DO NOT PRESENT CANCELLED CHECKS, CREDIT CARD OR CASH RECEIPTS.** THEY DO NOT CONTAIN THE INFORMATION NEEDED TO PROCESS A CLAIM. INCOMPLETE INFORMATION WILL ONLY DELAY PAYMENT

PLEASE VERIFY THAT THE RECEIPT CONTAINS THE FOLLOWING INFORMATION ABOUT THE PRESCRIPTION(S):

- ☐ Pharmacy Name
- ☐ NPI/NABP Number
- ☐ Pharmacy Address
- ☐ Phone Number
- ☐ Patient Name
- ☐ Rx Number
- ☐ Date Dispensed
- ☐ Name of Drug Dispensed
- ☐ NDC Number of drug
- ☐ Days Supply
- ☐ Quantity
- ☐ Amount Paid

Name of Physician: _____

The Ventegra staff is available to assist members and pharmacies having difficulty submitting claims for any reason. Our pharmacy network is able to process your claims within a 30 day window.

REMINDERS!!

*Include all original receipts. NO PHOTO COPIES.
Have you answered all the questions that are applicable to your claim?