



PRESCRIPTION DRUG CLAIM FORM

PLEASE USE PEN AND COMPLETE ALL ITEMS (PLEASE PRINT CLEARLY)
PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER.

Instructions

- 1. This form may be used for prescription drug expenses.
- 2. Complete this form and sign your name at the bottom.
- 3. Attach this form to itemized prescriptions or a computer printout signed by the pharmacist for every expense you are requesting reimbursement.
- 4. It is helpful if individual receipts are taped to a sheet of paper.
- 5. Mail this form with attachments to:
NCAS
PO Box 10136
Fairfax, VA 22038

PERSONAL INFORMATION

Employee/Subscriber's Social Security Number:	Howard County Public Schools		
Employee/Subscriber's Name:			
First	M.I.	Last	
Dependent's Name:			
First	M.I.	Last	
Address:			
Street	City	State	Zip

Total number of prescription enclosed:	
Date of oldest prescription enclosed:	
Date of most recent prescription enclosed:	
Total charges of all prescriptions enclosed:	

Payment for this claim should be received within three to four weeks of your submission. If payment has not been received, please contact Customer Service at 1-866-219-9292 or visit the internet at www.ncas.com, click FOR MEMBERS on the home page, click NCAS Online Self Service, for the User ID and Password type in your Group ID (hc) in lower case then click on LOGIN to set up your internet access to claims information.

Employee/Subscriber's Signature: _____ **Date:** _____