Prescription Reimbursement Claim Form

Secondary / Tertiary Coverage
Medicare Eligible

ALL CLAIMS MUST BE FILED WITHIN 1 YEAR OF DATE OF SERVICE

RETIREE INFORMATION

Retiree Name (Last Name, First Name) **Retiree Card ID #**

Phone **Retiree Date of Birth** (DD/MM/YYYY)

PATIENT INFORMATION

☐ **Patient is Retiree** (If the patient is NOT the retiree, please complete this section.)

Patient Name (Last Name, First Name) **Patient Date of Birth** (DD/MM/YYYY)

CERTIFICATION AND AUTHORIZATION

I certify that all the above statements are correct and complete and that the attached bill(s) represent actual services, dates and fees charged to me or my eligible dependents. I authorize the plan to take any appropriate action to receive expenses paid as the result of the acts or omissions of another person.

Retiree Signature **Date**

NOTE: A photocopy of the above authorization is as valid as the original.

INSTRUCTIONS

1. Complete all sections and sign this claim form.
2. Attach a copy of your Explanation of Benefits:
   - **If you are covered by Medicare AND HAVE American Airlines Retiree Medical Benefits** (retired prior to November 1, 2012), attach your United Health Care (UHC) Explanation of Benefits (EOB) and a copy of your UHC claim form.
   - **If you are covered by Medicare and DO NOT have American Airlines Retiree Medical Benefits**, attach your Medicare Explanation of Benefits (EOB).
3. Mail claim form and attachments or scan/email all documents to:

BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055
apaclaims@benecardpbf.com

If you have questions you can contact BeneCard PBF at 1-888-907-0070 / TDD: 1-888-907-0020.