



## Prescription Drug Coordination of Benefits (COB)

Participant: Use this form to request reimbursement under MUST when you or your dependents have primary prescription drug coverage with another insurance plan or have a MUST secondary plan.

*Refer to the Pharmacy Benefit section ("Primary Coverage Under Another Plan") of the MUST Summary Plan Description for more information about coverage eligibility.*

MUST SECONDARY PRESCRIPTION COVERAGE		
<b>Participant Information</b>	Name on MUST ID card	
	MUST Employee ID Number	
<b>Employer Information</b>	MUST Group Name	
	MUST Group Number	
<b>Prescription Information</b>	<i>Prescriptions were prescribed for</i> <input type="checkbox"/> Myself <input type="checkbox"/> My spouse (Provide name: _____) <input type="checkbox"/> My dependent (Provide name: _____)	

**Instructions:**

1. Fill out information above concerning your secondary prescription coverage. (If submitting pharmacy receipts for more than one dependent child, attach a separate sheet for each.)
2. Attach pharmacy receipts for each purchase. The receipts must include
  - ▶ The name of the drug
  - ▶ Whether the drug is "generic" or "brand"
  - ▶ The full retail cost *and* any copayment amount paid under the primary coverage.
3. Enclose any Explanation of Benefits (EOB) that you received for this purchase from the primary insurance plan (if applicable).
4. Mail all documents to

MUST Claims Administration  
 P.O. Box 3777  
 Missoula, MT 59806-3777