Prescription Drug Coordination of Benefits

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 eligibility for coverage.

PRIMARY PRESCRIPTION COVERAGE		
Participant Information	Name on other insurance ID card:	
	Plan ID Number:	
Employer Information	Group Name:	
	Group Number:	

MUST SECONDARY PRESCRIPTION COVERAGE		
Participant Information	Name on MUST ID card:	
	MUST ID Number:	
Employer Information	MUST Group Name:	
	MUST Group Number:	
Prescriptions were purchased for:	☐ Myself ☐ My spouse *(Provide name:_________________________________)* ☐ My dependent *(Provide name: _______________________________)*	

Instructions:

1. Fill out both sections above to provide information about your primary and 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 that you 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
   PO Box 3777
   Missoula, MT 59806-3777