

CareCLAIM Supplemental Information Form

Fax to: (903) 455-3797

Pharmacy: _____
Address: _____
City, State, Zip: _____
Phone #: _____
NABP: _____

Mail To: OmniSYS, Inc.
c/o CareCLAIM
P.O. Box 8489
Greenville, TX 75404-8489

Patient Information

HICN: _____ Effective Date: _____
Last Name: _____ First Name: _____ MI: _____ Gen: _____
Address: _____ Sex: _____ DOB: _____
City: _____ State: _____ Zip+4: _____
Phone No: _____ SSN: _____

Other Insurance

Insurance Name: _____ Phone No.: _____
Cardholder ID: _____ Address: _____
Plan/Group No: _____ City: _____
Group Name: _____ State: _____ Zip+4: _____

*****CLAIM(S) WILL NOT BE PROCESSED WITHOUT COMPLETE ADDRESS INFORMATION*****

Insured's Information

Last Name: _____ First Name: _____ MI: _____ Gen: _____
Address: _____ Sex: _____ DOB: _____
City: _____ State: _____ Zip+4: _____
Phone No: _____ Relationship: Self _____ Spouse _____ Other _____

Physician's Diagnosis/Narrative Record:

Responsible Party

Name: _____
Address: _____
City: _____ St: _____ Zip+4: _____

Facility/Laboratory

Name: _____
Address: _____
City: _____ St: _____ Zip+4: _____

Pharmacist: Complete and Fax Supplemental Information Form When

1. Patient's last name exceeds 15 characters.
2. Patient has a Legal Representative or Responsible Party.
3. Patient resides in a facility.
4. Patient secondary insurance or insured information is required.
5. Narrative record is required.

Questions: Call CareCLAIM Support at (877) 664-2234.