



Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for status of this request.

Prescription Drug Claim Form & COVID-19 OTC Test Kit Claim Form

Return this completed form with receipt(s) to:
PreferredOne Insurance Company
6105 Golden Hills Drive
Golden Valley, MN 55416-1023

1. Please submit a separate form for each patient for which you purchased medications.
2. Reimbursement will be made directly to the CARDHOLDER.
3. Include original receipt(s) or printout(s); Tape original receipt(s) to the bottom of this page. PLEASE DO NOT STAPLE.
4. Receipt(s) MUST contain the information outlined below. If your receipt(s) are missing any of this information, please attach it to this form and submit.
5. Receipt(s) will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

SUBSCRIBER INFORMATION

ID Number		Telephone Number	
Members First Name		Members Last Name	
Address	City	State	Zip Code
Patients First Name		Patients Last Name	
Patients Date of Birth	Patients Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Signature of Member		Date Signed	

Coordination of Benefits (COB)

Does Patient have other Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	ID Number:
Name of Carrier:	Carrier Address

Pharmacy/Online/Retailer Information

Pharmacy/Online/Retailer Name		Telephone Number	
Address	City	State	Zip Code

Receipt Information COVID-19 Test Kit

Date of Purchase	Product Name		
National Drug Code (NDC) or Universal Product Code (UPC)		Quantity of COVID Test/s in package	
Original Cost	Member Paid Amount		

Receipt Information Prescription Drug Claims

Date Filled	Drug Name	Physician Name	Member Cost

Continue to page 2



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Claims Receipts: Tape your receipts in box below. Your prescription claim receipts must accompany this form. The receipts must contain the following information:

- Date prescription was filled
- Prescription Number
- Doctors name
- Pharmacy name
- Drug name and strength
- Quantity
- Amount paid