



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 Humana Explanation of Benefits (EOB) and a copy of your Humana 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.