



**INSTRUCTIONS**  
**PLEASE PRINT ALL SECTIONS**

1. This form is to be used to claim prescription drug benefits provided to eligible HIP Medicare PDP or HIP Medicare HMO subscribers.
  
2. Please complete **all** sections. We need **all** the information requested to process your claims.
  
3. Have your pharmacist complete sections C, D1, D2, and D3. **Receipts must be attached.**
  
4. Use a separate form for each subscriber/patient. In addition, use a separate form for each pharmacy serving the patient.
  
5. Send the form to: HIP Medicare Prescription Drug Plan, P.O. Box 1520 JAF Station, New York, NY 10116-1520.
  
6. If you have OTC benefits (which includes coverage for analgesics, proton pump inhibitors, cough/cold medicines or antacids) please attach your itemized receipts and return. You do not need to complete Section C.