



**MANUAL CLAIM FORM  
VTPOP CLAIM - NCPDP vD.0**

**Return to: Goold Health Systems, Inc.  
1 Greentree Drive, Suite 2  
S. Burlington, VT 05403  
Fax Number: 1-844-679-5366**

Patient Name		Cardholder ID				Pharmacy Name				NABP					
Street Address		City		Plan Name		Patient DOB		Gender		Pharmacy Address				NPI	

**Claim 1**

Comments:				Other Coverage Code				Total Amount Billed					
Rx Number		Ref #	Prescriber NPI #		Prescriber Name			Date Prescribed		Date Filled		Quantity	Days' Supply
PA #		MN	Drug Name, Strength, Dosage, Mfg.			NDC			Primary Copay		Submission Clarification Code		

**Coordination of Benefits (COB) – Other Payer Information**

Other Payer ID		ID Qual.			Other Payer Date			OPAP				OPPRA	
1								Qual		Amt		Qual	Amt
2								Qual		Amt		Qual	Amt

**Claim 2**

Comments:				Other Coverage Code				Total Amount Billed					
Rx Number		Ref #	Prescriber NPI #		Prescriber Name			Date Prescribed		Date Filled		Quantity	Days' Supply
PA #		MN	Drug Name, Strength, Dosage, Mfg.			NDC			Primary Copay		Submission Clarification Code		

**Coordination of Benefits (COB) – Other Payer Information**

Other Payer ID		ID Qual.			Other Payer Date			OPAP				OPPRA	
1								Qual		Amt		Qual	Amt
2								Qual		Amt		Qual	Amt

Provider Signature				Date Signed			