

Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.



Subscriber Information *See your ID card.*

Identification # _____

Rx Group # _____

Member Name (First, Last) _____

Street Address _____

City _____ State Zip

Patient Information

Patient Name (First, Last) _____

Patient Date of Birth (Month/Day/Year)

Gender Relation to Plan Subscriber

- Female ₁ Self
 Male ₂ Spouse
 ₃ Dependent

Pharmacy Information

Name of Pharmacy _____

Street Address _____

City _____ State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

Claim Receipts

Tape claim receipts or itemized bills on the back. **Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

- Is a compound prescription.***
Make sure your pharmacist lists ALL the NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM PER COMPOUND PRESCRIPTION.

- Was purchased outside the U.S.A.**
If so, please indicate:

Country _____

Currency used _____

- Is for treatment of an allergy.**

* A compounded medicine is a blend of ingredients that the pharmacist prepares especially for you at your prescriber's request. To be covered under your pharmacy benefit, a compounded medicine must have at least one ingredient that is a prescription drug with an FDA-approved therapeutic indication.

- Check here if the patient has other prescription coverage. Medicare supplement subscribers need not complete this section.**

Who is the primary carrier? _____

(See your health plan benefit booklet for definitions of primary and secondary.)

Check one:

- Receipt is for primary coverage
 Receipt is for secondary coverage

If for secondary coverage:

- Receipt indicates the total price paid for the prescription; or
 Receipt indicates the copayment amount paid under primary coverage

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____

Signature of Patient (or legal guardian if patient cannot legally consent to services)

