

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Member information

RxGroup (see ID card)		Member ID (see ID card)
Last name	First name	MI
Mailing street address		Apt. #
City	State	ZIP
Prescription is for <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent		Date of Birth (mm/dd/yyyy)

2 Custodial parent information

For reimbursement requests from a parent for a child (under the age of 18) when the requesting parent meets both of the following requirements:

1. Parent is not enrolled in the same Group Health plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Group Health plan

If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.

Legal custodian's name	Legal custodian's contact phone
Custodian requesting reimbursement name	Custodian requesting reimbursement contact phone
Address payment is to be mailed to	

3 Physician and pharmacy information

Prescribing physician name	Dispensing pharmacy name
Prescribing physician phone number with area code	Dispensing pharmacy phone number with area code

4 Reason for request Select appropriate options for your request

- | | |
|---|---|
| <input type="checkbox"/> I did not use my Prescription Drug ID card
<input type="checkbox"/> I used a non-participating pharmacy (please explain)

<input type="checkbox"/> I filled a compound prescription (your pharmacist must complete section B on the back of this form)
<input type="checkbox"/> I purchased medication outside of the United States
Country _____
Currency used _____ | <input type="checkbox"/> My primary coverage is with another insurance carrier (coordination of benefits claim; see section C on back for details)
<input type="radio"/> I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
<input type="radio"/> I am submitting a copay receipt
<input type="checkbox"/> I was waiting for a drug approval
<input type="checkbox"/> I was retroactively enrolled with the plan
<input type="checkbox"/> My pharmacy billed the wrong plan
<input type="checkbox"/> Other (please explain) _____
_____ |
|---|---|

5 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ Date: _____



The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通，我们提供一些免费服务，例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助，请拨打您的 ID 卡上列出的免费电话号码。