

## 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="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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="checkbox"/> I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare <input type="checkbox"/> 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: \_\_\_\_\_

