

## **Prescription Reimbursement Claim Form**

# Important!

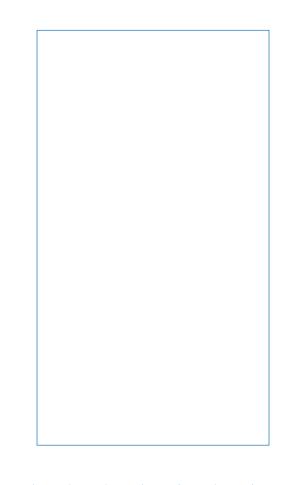
- Allow up to 30 calendar days for processing to receive a response to your claim
- Keep a copy of all documents submitted for your records
- Do not staple receipts or attachments to this form
- Reimbursement is not guaranteed and may not equal the amount paid

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## **Card Holder/Patient Information**

This section mus	st he fulls	completed to ensi	ure proper reimburse	ement of your claim
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Discussion Continued				
Pharmacy Information Continued		NEO NO	MARRO MIRLS	
Phone Number Is this an on site nursing ho	me pharmacy?	YES NO	NCPDP/NPI Required	
X				
Signature of Pharmacist or Representative (REQUIRED)				
Important! A signature is REQUIRED				
Any person who knowingly and with intent to defraud, injure, or deceive a false, deceptive, incomplete or misleading information pertaining to such subject such person to criminal or civil penalties, including fines, denial of	claim may be o	committing a fraudu		
I certify that I (or my eligible dependent) have received the medicine description entered on this form is true and correct.	ribed herein. I c	ertify that I have rea	d and understood this form, and that all the	
X				
Signature of Plan Participant (REQUIRED)		Date		
STEP 2 Submission Requirements				
You MUST include all original "pharmacy" receipts for your claim to be supplies. You may need to ask for a special receipt.	oe reviewed. C	ash register receip	ts will be accepted for diabetic	
<ul> <li>The minimum information that must be included on your pharmacy reservation.</li> <li>Patient Name         <ul> <li>Prescription Number</li> <li>Date of Fill             <ul> <li>Amount and Type of Drug (4 table)</li> <li>Days Supply for your prescription (you need to ask your pharmacist for the Pharmacy Name and Address or Pharmacy NCPDP Number</li> </ul> </li> </ul></li></ul>	ets, for example	e)	<ul><li> Medicine NDC Number</li><li> Total Charge</li></ul>	
Please provide a valid Prescribing Physician's NPI:				
Prescribing physician's information:				
Name:				
Address:				
City:		State:	Zip:	
Phone:			·	
Additional comments:				
STEP 3 Mail completed forms with receipts to: Claims Department P.O. Box 52065 Phoenix, AZ 85072-2065	OR	Fax comple Fax: 401-404-6	ted forms with receipts to:	
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### To avoid having to submit a paper reimbursement claim form:

- Always have your ID card available at time of purchase
- Use medication from your preferred drug list
- Always use pharmacies within your plan
- Return to the pharmacy to request claim reprocessing and for reimbursement
- If problems are encountered at the pharmacy, call the Pharmacy Member Services number on your ID card