

MEMBER REIMBURSEMENT CLAIM FORM

Please mail this claim form directly to:



informedRx Manual Claims
P.O. Box 5206
Lisle, IL 60532-5206

For assistance please call:
(8 0 0) 8 8 0 - 1 1 8 8
24 hours a day, 7 days a week

Please print or type this information

Group#	<input type="text"/>	I.D. #	<input type="text"/>
Plan/Employer Name: (REQUIRED)			
Cardholder's Last Name:		First Name:	Middle Initial:
Cardholder's Street Address:		City:	State: Zip:
() <input type="text"/> - <input type="text"/>		() <input type="text"/>	<input type="text"/> - <input type="text"/>
Cardholder's Day Time Phone Number:		Cardholder's Evening Phone Number:	
<input type="text"/>		<input type="text"/>	
Patient's Name: (Use a separate claim form for each covered family member)		Patient's Date of Birth	
<input type="checkbox"/> Female <input type="checkbox"/> Male <small>Patient's Gender</small>		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <small>Patient's relationship to cardholder</small>	

WITHOUT PHARMACIST SIGNATURE - PHARMACY LABEL RECEIPTS ARE REQUIRED

1	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay <input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx <input type="checkbox"/> Vaccine Vaccine Administration Fee you Paid (if any) \$ _____		Pharmacy Address & Phone Number		
2	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay <input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx <input type="checkbox"/> Vaccine Vaccine Administration Fee you Paid (if any) \$ _____		Pharmacy Address & Phone Number		

CLAIM WILL BE RETURNED IF REQUIRED INFORMATION IS MISSING

Date: _____ Cardholder's Signature _____
 Date: _____ Pharmacist's Signature _____

I certify that all information on this claim form is accurate. I understand that informedRx, Inc.'s use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

MEMBER REIMBURSEMENT CLAIM FORM (CONTINUED)

Group #	<input type="text"/>	ID #	<input type="text"/>
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WITHOUT PHARMACIST SIGNATURE - PHARMACY LABEL RECEIPTS ARE REQUIRED

3	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay <input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx <input type="checkbox"/> Vaccine Vaccine Administration Fee you Paid (if any) \$ _____		Pharmacy Address & Phone Number		

4	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay <input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx <input type="checkbox"/> Vaccine Vaccine Administration Fee you Paid (if any) \$ _____		Pharmacy Address & Phone Number		

5	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay <input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx <input type="checkbox"/> Vaccine Vaccine Administration Fee you Paid (if any) \$ _____		Pharmacy Address & Phone Number		

6	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay <input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx <input type="checkbox"/> Vaccine Vaccine Administration Fee you Paid (if any) \$ _____		Pharmacy Address & Phone Number		

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Cash register receipts are not accepted. Please make copies for your records - documents will NOT be returned.

Questions? Call (8 0 0) 8 8 0 - 1 1 8 8