



MEMBER REIMBURSEMENT CLAIM FORM

Complete this form, attach prescription labels and mail to:

InformedRx
P.O. Box 5206
Lisle, IL 60532- 5206

IMPORTANT!

- Do not forget to submit your prescription label receipt(s)
- Keep a copy of this form and documents for your records

Cardholder Information

Group/Employer/Union Name (REQUIRED): _____		Cardholder ID#: _____	
Cardholder's Last Name: _____		First Name: _____	Middle Initial: _____
Cardholder's Street Address: _____		City: _____	State: _____ Zip: _____
Check here if this is a new address or has changed since your last manual claim submission: <input type="checkbox"/>			
() _____ - _____ @ _____	Number of prescription labels submitted: _____		
Cardholder's Phone Number: _____		Cardholder's Email Address: _____	

Patient Information (one form per patient)

Patient's First and Last Name: _____		Patient's Date of Birth: _____	
<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
Patient's Gender:		<input type="checkbox"/> Child	<input type="checkbox"/> Other
Patient's relationship to cardholder:			

Reason for Request (check appropriate reason)

<input type="checkbox"/> Coordination of benefits with primary pharmacy or medical plan. (Please confirm your plan allows coordination of benefits before submitting)	<input type="checkbox"/> Out of area urgent/emergency request
<input type="checkbox"/> Compound claim	<input type="checkbox"/> Out of area vacation request
<input type="checkbox"/> Covered vaccine or vaccine administration fee	<input type="checkbox"/> Eligibility issue at the pharmacy
	<input type="checkbox"/> Other, please describe: _____

Alternate Insurance/Coordination of Benefits (COB)

Is the prescription(s) covered under any other plan? Yes No

Primary pharmacy or medical plan name: _____

Primary Member/Subscriber's Name: _____

Important - Signature is REQUIRED!

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Date: _____ Cardholder's Signature _____

Special Instructions:

- ☑ Complete and return this form when you have purchased a prescription drug and are seeking reimbursement.
- ☑ Submit this form with the original prescription label receipt(s) or the pharmacy printout signed by the pharmacist.
- ☑ Prescription label receipt obtained from the pharmacy must have the following information clearly legible:
 - Pharmacy name, location and NABP# or NPI#
 - Drug name, NDC#, strength, quantity and day supply dispensed.
 - Prescribing physician's name
 - Total amount paid for the prescription
 - Prescription number and date filled
- ☑ **Cash register receipts and credit card receipts are not acceptable forms of prescription label receipts.**
- ☑ If your plan allows copay reimbursement (COB), please make sure the pharmacy label receipt shows the copay you paid through your primary pharmacy plan.
- ☑ All restrictions, exclusions and limits as defined in your plan apply to all claims for direct member reimbursement.
- ☑ DO NOT remove the labels from your medication bottle or box, submit the pharmacy label receipt provided at the time of your purchase.
- ☑ INCOMPLETE forms or prescription label receipts with missing or incorrect information may delay payment or cause the form to be returned to you.
- ☑ Please allow 30 days for processing.
- ☑ For questions concerning this claim, please call the toll free number listed on your pharmacy ID card.