MEMBER REIMBURSEMENT CLAIM FORM

Complete this form, attach prescription labels and mail to:

informedRx
P.O. Box 5216
Lisle, IL 60532- 5216

IMPORTANT!

Do not forget to submit your prescription label receipt(s)

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: ☐

( ) —

Cardholder's Phone Number:

@

Cardholder's Email Address:

Number of prescription labels submitted:

Patient Information (one form per patient)

Patient's First and Last Name:

/ /

Patient's Date of Birth

☐ Female ☐ Male

Patient's Gender:

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's relationship to cardholder:

Reason for Request (check appropriate reason)

- ☐ Coordination of benefits with primary pharmacy or medical plan. (Please confirm your plan allows coordination of benefits before submitting)
- ☐ Compound claim
- ☐ Covered vaccine or vaccine administration fee
- ☐ Out of area urgent/emergency request
- ☐ Out of area vacation request
- ☐ Eligibility issue at the pharmacy
- ☐ 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.