



Prescription Drug Program Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s).**

Cash register and credit card receipts alone are not acceptable as proof of purchase.

Reimbursement is not guaranteed.

Claims will be reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (one form per patient)

Health Plan/Insurance Name & State <i>(please print)</i>	Group/Employer Name	Union Trust No. (if applicable)
Name <i>(Last Name, First Name, MI)</i>	Birth Date	I.D. Number
Mailing Address <i>(Number, Street, City, State & Zip Code)</i>		Social Security Number
Prescribing Physician's Name		Physician's Telephone Number

Reason For Request

(At least one must be checked)

- | | |
|---|--|
| <input type="checkbox"/> Out of Area urgent/emergent medication | <input type="checkbox"/> Referral non-contracted physician/self referral |
| <input type="checkbox"/> Non urgent medication/vacation request | <input type="checkbox"/> Compound medication |
| <input type="checkbox"/> No identification card or identification number available | <input type="checkbox"/> Non-contracted pharmacy |
| <input type="checkbox"/> Eligible member/group invalid | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Coordination of Benefits (From Primary insurance - complete section below) | |

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription, please complete this section.)

Primary Health Plan/ Insurance Company Name _____

Primary Member/Subscriber's Name *(Last Name, First Name, MI)* _____

Primary Member/Subscriber's ID _____

I certify that the patient for whom this claim is made is a covered person in this Prescription Drug Program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X _____
Member's/Subscriber's Signature Date

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- Pharmacy Name
- Prescription number and date filled
- Drug name, strength, and quantity
- Member paid expense
- Prescribing physician's name

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

**Prescription Solutions
Mail Stop LC07-190; ATTN: Claims Department
P.O. Box 6037
Cypress, CA 90630-0037**

Reimbursement and correspondence will be issued to the primary member/subscriber.