

Prescription Drug Reimbursement Claim Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.



Member/Subscriber Information *See your prescription drug ID card.*

Group No. **U A R X B E N**

Member ID

Member Name (First, Last) _____

Street Address _____

City _____ State Zip

City _____ State Zip

City _____ State Zip

Patient Information

Patient Name (First, Last) _____

Patient Date of Birth (Month/Day/Year)

Sex *Relation to Plan Member*
 Female 1 Self 5 Disabled Dependent
 Male 2 Spouse 6 Domestic Partner
 3 Eligible Child 7 Other
 4 Dependent Student

Pharmacy Information

Name of Pharmacy _____

Street Address _____

City _____ State Zip

City _____ State Zip

City _____ State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

Claim Receipts

Tape claim receipts or itemized bills on the back.

Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

Is a compound prescription
If so, make sure your pharmacist lists all the ingredients and quantities on the receipt.

Was purchased outside the U.S.A.
If so, please indicate:

Country _____

Currency used _____

Is for treatment of an allergy

Please tape receipts on the back.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I authorize the release of all information to the plan administrator, underwriter, sponsor, policyholder, employer, and their agents for use in connection with the benefit plan programs. This information may also be used for other reporting and analysis purposes without identification of me or my family members. I further authorize the use of my Social Security number for identification purposes. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of Member

Claim Receipts

Please tape your receipts here. **Do not staple!**

Tape receipt for Rx 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Total cost of medication

Tape receipt for Rx 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Total cost of medication

Tape receipt for Rx 3 here.

Tape receipt for Rx 4 here.

Direct Reimbursement Claim Instructions Read carefully before completing this form.

1. Always present your medical/prescription drug ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid a pharmacy full price for a prescription drug order because:
 - The pharmacy does not accept your Blue Cross Blue Shield/Medco prescription ID card, or
 - You have not received your Blue Cross Blue Shield/Medco prescription ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient**.
4. You must submit claims within 1 year of date of purchase or as required by your plan.

Visit us on the Web at www.medco.com.

5. **Be sure your receipts are complete.**
In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
6. The plan member should read the Acknowledgment carefully, then sign and date this form.
7. Return the completed form and receipts to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

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