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.**

Patient Information *(one form per patient)*		
Health Plan/Insurance Name & State *(please print)*	Group/Employer Name	Union Trust No. (if applicable)
Name *(Last Name, First Name, MI)*	Birth Date	ID Number
Mailing Address *(Number, Street, City, State & Zip Code)*		Social Security Number
Prescribing Physician's Name		Physician's Telephone Number

Reason For Request

(At least one must be checked)

- ☐ Out-of-Area urgent/emergency medication
- ☐ Non-urgent medication/vacation request
- ☐ No identification card or identification number available
- ☐ Eligible member/group invalid
- ☐ Coordination of Benefits (From primary insurance - complete section below)
- ☐ Referral or non-contracting physician/self-referral
- ☐ Compound medication
- ☐ Non-contracted pharmacy
- ☐ Other ______________________________

Coordination of Benefits

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

Primary Health Plan/Insurance Company ______________________________

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 payment could be delayed or denied.

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

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

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

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