



# Prescription Drug Reimbursement Form

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

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

Group No.

Member ID

Member Name (First, Last)

Street Address

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 Dependent Parent
- 3 Eligible Child  7 Other
- 4 Dependent Student  8 Non-spouse Partner

## Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code)

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

I hereby certify that the charge(s) shown for the medications prescribed is/are correct and agree to provide Medco Health or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

Signature of Pharmacist or Representative (Required) NABP Number Required

## 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.**  
Make sure your pharmacist lists ALL the NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

**ONE CLAIM FORM PER COMPOUND SUBMISSION.**

- 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/were received for use by the patient listed above, and that I (and 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 recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

Signature of Member

