Prescription Drug Reimbursement Form

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

Customer Information *See your ID card.*

Group No. U H E A L T H

Customer ID

Customer Name (First, Last)

Street Address

City State Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex
- ☐ Female
- ☐ Male

Relation to Plan Customer
- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Other
- ☐ 8 Non-Spouse Partner

Pharmacy Information

Name of Pharmacy NABP Number

Street Address

City State Zip

Telephone (include area code)

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

If yes, I hereby certify that the charge(s) shown for the medications prescribed is (are) correct and agree to provide Medco 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 customer and assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Pharmacist or Representative **(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 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 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 Customer

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them to a separate piece of paper.

Tape receipt for prescription 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)
- Amount paid

Tape receipt for prescription 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)
- Amount paid

Pharmacy Information (For Compound Prescriptions ONLY)

- List each NDC number for ALL ingredients used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to the claim form.

RX#: **Date of Service:** **Days' Supply:**

NDC#	QTY
TOTAL CHARGE	

Direct Reimbursement Claim Instructions
Read carefully before completing this form.

1. Always present your 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 ID card, or
   - You have not received your 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.
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 customer 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 2096
   Lee's Summit, MO 64063-7096