



PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Member Information

RxGroup (see ID card)			Member ID (see ID card)		
Last Name		First Name		MI	
Mailing Street Address					Apt. #
City	State	ZIP	Prescription is for <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent		Gender <input type="radio"/> M <input type="radio"/> F
Date of Birth (mm/dd/yyyy)			<input type="text"/> / <input type="text"/> / <input type="text"/>		

2 Physician and Pharmacy Information

Prescribing Physician Name		Dispensing Pharmacy Name	
Prescribing Physician Phone Number with Area Code		Dispensing Pharmacy Phone Number with Area Code	

3 Reason For Request

Select appropriate options for your request:

- I did not use my Prescription Drug ID card
- I used a non-participating pharmacy (please explain) _____
- I filled a compound prescription (your pharmacist must complete section B on the back of this form)
- I purchased medication outside of the United States
 Country _____ Currency used _____
- I was waiting for a drug approval
- I was retroactively enrolled with the plan
- My pharmacy billed the wrong plan
- Other (please explain) _____

4 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ **Date:** _____



