PrescriptionSolutions

# 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.**

**Reimbursement is not guaranteed.**

Claims will be reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

## Patient Information (one form per patient)

| | | |
|---|---|---|
| Health Plan/Insurance Name & State *(please print)* | Group/Employer Name | HIC Number |
| Name *(Last Name, First Name, MI)* | Birth Date | I.D. Number |
| Mailing Address *(Number, Street, City, State & Zip Code)* | | Social Security Number |
| Prescribing Physician's Name | | Physician's Telephone Number |

## Reason For Request

Write reason here:

## Coordination of Benefits

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

**An Explanation of Benefit from the primary insurance must include the dollar amount paid by the primary insurance.**

Primary Health Plan/ Insurance Company Name _____

Primary Member/Subscriber's Name *(Last Name, First Name, MI)*_____

## Compound Prescriptions Only (Pharmacist signature required)

- List the VALID 11 digit NDC number (highest to lowest cost) in the box at the right for EACH ingredient 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 provided with claim form

| Rx# | | Date Filled | | Days' Supply | |
|---|---|---|---|---|---|

| Valid 11 digit NDC# | Quantity |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| **Total Quantity** | |
| **Total Charge** | |

**Signature of Pharmacist X** _____

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.

**Member's/Subscriber's Signature X** _____ Date _____

***Special Instructions:***

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- Pharmacy Name
- Drug name, strength, and quantity
- Prescribing physician's name
- Prescription number and date filled
- 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**
**P.O. Box 29044**
**Hot Springs, AR 71903**

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



PEX6710-004
RxSol Rev 082109