

MEMBER REIMBURSEMENT DRUG CLAIM FORM (CONTINUED)

RxGrp# <input type="text"/>	I.D. # (SSN) <input type="text"/>
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(See ID Card for number)

WITHOUT PHARMACIST SIGNATURE - PHARMACY LABEL RECEIPTS ARE REQUIRED

Date: _____ Pharmacist's Signature _____

1	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				
2	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				
3	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				
4	Fill date _____	RX# _____	Quantity _____	Day Supply _____
Drug Name _____				
NDC # <input type="text"/>		Pharmacy NPI <input type="text"/>		
Amount You Paid. \$ _____ <input type="checkbox"/> Full Price <input type="checkbox"/> Co-Pay		Pharmacy Address & Phone Number		
<input type="checkbox"/> Compound <input type="checkbox"/> Regular Rx				

CLAIM WILL BE RETURNED IF REQUIRED INFORMATION IS MISSING

Cash register receipts are not accepted. Please make copies for your records - documents will NOT be returned.

Questions? Call (8 6 6) 6 3 5 - 6 9 0 6