

# Prescription Drug Reimbursement Form

Before completing this form see the back for instructions.

Complete all information. An incomplete form can delay your reimbursement.

## Member/Card Holder Information

See your medical / prescription ID card.

Group No. **G M 0 0 0 0 0**

Member Identification Number

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*

- |                                 |  |   |
|---------------------------------|--|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self              | <input type="checkbox"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male   | <input type="checkbox"/> 2 Spouse            | <input type="checkbox"/> 6 Dependent Parent   |
|                                 | <input type="checkbox"/> 3 Eligible Child    | <input type="checkbox"/> 7 Other              |
|                                 | <input type="checkbox"/> 4 Dependent Student | <input type="checkbox"/> 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 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.

**X**  
Signature of Pharmacist or Representative  
(Required)

NABP Number Required

## 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.

**X**  
Signature of Member

## 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 VALID 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.**

## Reason for Claim *Mark one.*

- A Nursing home resident  
 B Lost or have not yet received prescription ID card  
 C Unable to locate a Medco participating retail pharmacy  
 D Medicare eligible  
 E Other prescription benefit coverage  
 F Other (please explain below)

**Please tape receipts on the back**

