Prescription Drug Reimbursement Form

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

party is void.

X Signature of Member

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Member/Subscriber Information See your prescriber Information	Tape receipts or itemized bills on the back. See back for details.
Member Name (First, Last)	Check the appropriate box if any receipts or bills are for a:
Street Address City State Z	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
Patient Information Patient Name (First, Last) Patient Date of Birth (Month/Day/Year)	if incomplete. ONE CLAIM FORM PER COMPOUND SUBMISSION
Sex Relationship to Plan Member □ Female □ 1 Self □ 2 Spouse □ 3 Eligible Child □ 7 Nonspou □ 4 Dependent Student □ 8 Other	ent Parent Please indicate:
Pharmacy Information	☐ Allergy medication
Name of Pharmacy	Any person who knowingly and with inten
Street Address City State Z	Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing.
Telephone (include area code)	a fraudulent insurance act which is a crime
Is this an on-site nursing home pharmacy? I hereby certify that the charge(s) shown for the medication(s) prescribed is correct an Medco or its agents reasonable access to records related to medication dispensed to the dance with applicable law. I further recognize that reimbursement will be paid directly and assignment of these benefits to a pharmacy or any other party is void.	□ Yes □ No or civil penalties, including fines and/or dagree to provide imprisonment, or denial of benefits.*
X Signature of Pharmacist or Representative (Required) NABP Number	Please tape receipts on the back. Required
Acknowledgment	use by the patient listed above, and that I (or the patient, if not myself) am

eligible for prescription 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

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on 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 the VALID 11 digit NDC number 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 attached to claim form.

	RX#	Date Filled	Days Supply
	VALIC	11 digit NDC#	Quantity
-			
-			
		Total Quantity	/
		Total Charge	<u> </u>

Direct Reimbursement Claim Instructions Read carefully before completing this form.

- 1. Always present your prescription drug ID card at the participating retail pharmacy.
- 2. Only use this claim form when you have paid full price for a prescription drug order at a pharmacy because:
 - The pharmacy does not accept your Medco prescription drug ID card, or
 - You have not received your Medco prescription drug 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 your claim or bill is not itemized.
- 6. The plan member should read the acknowledgment carefully, then sign and date this form.
- 7. Return the completed form and receipt(s) to:

Medco Health Solutions, Inc. P.O. Box 14711 Lexington, KY 40512

- * California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- * Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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