# Direct Member Reimbursement

## CARDHOLDER INFORMATION

Cardholder ID# | RxGRP # | Plan Sponsor

Cardholder Name | Phone

Cardholder Address | City | State | Zip Code

## MEMBER INFORMATION

Member Name | Date of Birth (DD/MM/YYYY)

Relationship: ☐ PRIMARY ☐ SPOUSE ☐ CHILD ☐ OTHER Gender: ☐ FEMALE ☐ MALE

Member Name | Phone

Member Address | City | State | Zip Code

## SIGNATURE / RELEASE

By signing this form you certify that the information provided is accurate and authorize the release of all necessary information to all appropriate parties involved in the administration of this claim. All medications described herein were received by the named patient and he/she is eligible for benefits. None of the named medications described herein are covered under another benefit plan or for an on-the-job injury.

Signature (Member, Parent or Guardian) | Print Name | Date

## PRESCRIPTIONS FOR REIMBURSEMENT

**If you have original receipts, enclose them with this form, in which case, there is no need to complete the bottom of this form.** Be sure your itemized receipts include the following 1) Pharmacy Name 2) Pharmacy NABP# 3) Prescription Number 4) Date of Purchase 5) Total amount charged for each prescription 6) Medicine Name 7) Strength 8) Quantity Dispensed.

**If you don't have original receipts, ask your pharmacist for a copy or to complete and sign the bottom of this form.**
Pharmacist: By signing this form, you certify the information on this form below correctly represents the amount charged and the prescriptions dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member.

Signature (Pharmacist or Pharmacy Representative) | Print Name | Date

### Prescription #1

Rx Number | Date Filled | NDC# | Medicine

Strength | Day Supply | Quantity | ☐ New ☐ DAW | ☐ Refill ☐ Compound

Prescribers DEA# | Pharmacy NABP# | $ Total Cost | Approval (INTERNAL USE ONLY)

### Prescription #2

Rx Number | Date Filled | NDC# | Medicine

Strength | Day Supply | Quantity | ☐ New ☐ DAW | ☐ Refill ☐ Compound

Prescribers DEA# | Pharmacy NABP# | $ Total Cost | Approval (INTERNAL USE ONLY)

### Prescription #3

Rx Number | Date Filled | NDC# | Medicine

Strength | Day Supply | Quantity | ☐ New ☐ DAW | ☐ Refill ☐ Compound

Prescribers DEA# | Pharmacy NABP# | $ Total Cost | Approval (INTERNAL USE ONLY)

OVER

## COMPOUNDS

**To be completed by your pharmacist if the prescriptions being submitted for reimbursement are compound medications, even if you have itemized receipts:**

| NDC# | INGREDIENT | QUANTITY | COST |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Pharmacist signature:**_____

## INSTRUCTIONS

- Copy the Cardholder ID number and Group number (RxGRP) from your ID card.
- Your Plan Sponsor is your employer or the organization through which you receive benefits
- Be sure to read the release, sign and date this form certifying accuracy of the information provided.
- Retain copies of all documentation as forms and receipts submitted to EmpiRx Health will not be returned.

**Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan and only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.**

Be sure you have completed the form accurately and included the following for each prescription to be reimbursed. If you do not have the details or an itemized receipt, your pharmacist can assist you in completing the form and have them sign the front. If you are submitting a compound prescription for reimbursement, have your pharmacist complete and sign the top of this page, even if you do have an itemized receipt.

- Your prescription #
- Date of purchase
- Prescription NDC#
- Name of medicine
- Strength of the prescription
- Day supply
- Quantity
- Prescriber DEA#
- Pharmacy NABP#
- Prescription number
- Total cost for each prescription

Items not covered under your prescription benefit plan should not be submitted for reimbursement including Durable Medical Equipment. Diabetic supplies requiring a prescription are reimbursable only if covered by your plan. Canceled checks and cash register receipts are not acceptable forms of receipts to be submitted for reimbursement.

**Fraud Prevention** - Any person who knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

## MAIL COMPLETED FORM TO:

EmpiRx Health
PO Box 1339
Mechanicsburg, PA 17055

## QUESTIONS

If you have any questions, please contact Member Services at:
1-877-241-7123 TDD: 1-888-907-0020
24 hours a day, 365 days a year
www.empirxhealth.com