

Prescription Drug Reimbursement Form

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



Customer Information *See your ID card.*

Group No. **UHEALTH**
Customer ID

Customer 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 Customer*
 Female 1 Self 5 Disabled Dependent
 Male 2 Spouse 6 Dependent Parent
 3 Eligible Child 7 Other
 4 Dependent Student 8 Non-Spouse Partner

Pharmacy Information

Name of Pharmacy _____ NABP Number

Street Address _____
City _____ State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

If yes, 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 customer and assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of Pharmacist or Representative (Required)

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or 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 Customer

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 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

Please tape receipts on the back

