Direct Member Reimbursement Form

This form is to be used to request reimbursement for claims paid in full by Prescryptive members when the dispensing pharmacy was not able to directly submit the claim or you are requesting reimbursement and deductible credit for prescriptions purchased using SmartPRICE™.

PLEASE NOTE:

- Complete and accurate copies of original receipts and printed pharmacy labels for each claim must accompany this form submission. Electronic copies are acceptable.
- Reimbursement requests will be considered only within 90 days of the prescription purchase.
- Your claim will be reimbursed based upon your eligibility and plan benefit.
- Reimbursement will be made to the Primary Member and will be determined based upon the amount paid less applicable benefit co-pays or deductibles.
- Upon approval, a reimbursement check will be sent within 6-8 weeks of receipt of your request.
- Benefits coordination: If Prescryptive is providing secondary insurance coverage please disclose amount paid by your primary insurance and include receipt or denial letter from your primary insurance carrier.

Instructions:

1. Download this form and fill out completely. All fields are required unless marked as optional. If you have multiple family members requiring claim reimbursement, use one form per patient.
2. If you are submitting claims for prescriptions dispensed at multiple pharmacies, you must submit a separate claim form for each pharmacy.
3. More than 4 prescription claims will require a second form.
4. Fax or mail this form along with receipts and printed labels to:

Prescryptive Health, Inc.
Attention: Member Services
PO Box 403
Redmond, WA 98073
Fax: (855)708-4808

Note: Faxed submissions can be processed more quickly.
Forms with missing or illegible information will be returned.

prescryptive™

Direct Member Reimbursement Form (cont.)

Why do you need to file for reimbursement? (check one): ☐ Pharmacy Denied Claim ☐ Out of Network Pharmacy ☐ Traveling ☐ Other

MEMBER INFORMATION (Information can be found on Member ID card)

Employer Name:		Issuer Number:	
Rx PCN:	Rx BIN:	Rx Group:	
Primary Member (Last, First, MI):		Member ID:	
Patient (Last, First, MI):		Date of Birth (patient):	Patient Sex:
Relationship to Member: ☐ self ☐ spouse ☐ child ☐ other			
Mailing Address of Primary Member:			Patient Email Address:
City:	State: Choose State	Zip Code:	

PRESCRIPTION INFORMATION

	Rx CLAIM 1	CLAIM 2	CLAIM 3	CLAIM 4
Rx Number:				
Date Filled:				
Date Script Written:				
Name of Drug:				
NDC Number: (obtain from your pharmacy)				
Strength:				
Dosage Form:				
Manufacturer:				
Product Number:				
Metric Qty Dispensed:				
Day Supply:				
Prescriber NPI or DEA Number: (obtain from your physician)				
Original Cost of Prescription:				
Prescription Price Paid by Member:				
Benefit Coordination: Amount Paid by Primary Insurance, if applicable:				

PHARMACY INFORMATION

Pharmacy Name:			
Pharmacy Address:			
Pharmacy Phone Number:		Pharmacy NCPDP: (obtain from your pharmacy)	

I certify that the information on this form is correct and accurately reflects the prescriptions dispensed and prices I paid, and that these prescriptions are for the sole use of the named patients, and that the claims being submitted for payment are not eligible for payment under another prescription benefit.

Primary Member Signature _____ **Date** _____

Print _____ **Contact Phone Number** _____