

Pharmacy Reimbursement Claim Form

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



Enrollee Information *See your ID card.*

RxGrp

Enrollee ID

Enrollee Name (First, Last) _____

Street Address _____

City State Zip

Patient Information

Patient Name (First, Last) _____

Patient Date of Birth (Month/Day/Year)

Gender Relationship to Enrollee

Female ₁ Self

Male ₂ Spouse/Domestic Partner

₃ Eligible Child

Pharmacy Information

Name of Pharmacy _____

Street Address _____

City State Zip

Telephone (include area code)

Claim Receipts

(Please read Section A on back for details.)
Check the appropriate box if your receipts are for a:

Compound prescription
Make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and ingredients and quantities on the receipt.

Medication purchased outside of the United States
Please indicate:
Country _____
Currency used _____

Coordination of Benefits

(Another Health Plan has paid a portion)
Is this a coordination of benefits claim?
 Yes No

If yes, please read Section B on back for details, and mark the appropriate box for your primary coverage method.

₁ You are submitting an Explanation of Benefits (EOB) from another Health Plan

₃ You are submitting a copay receipt

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 a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Please tape receipts on the back.

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 prescription drug benefits. I also certify that the medication received was not for an on-the-job injury. 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 Enrollee

