Prescription Reimbursement Claim Form

Member/Patient Information

Member Name

Member ID

Patient Name

Date of Birth

Phone Number

Address

Prescription Information

Prescription Number (Rx No.)

Prescribing Doctor Name

Date of Prescription

Medication(s) Details

Drug Name	Quantity	Days Supply	Price Paid	Pharmacy Name	Pharmacy NPI/ID

Reason For Claim

Select Reason

If Other, please briefly explain...

Signature

Signature (type full name)

Date