Prescription Drug Reimbursement Form

1. PATIENT/MEMBER INFORMATION

Full Name

Date of Birth

Member ID Number

Phone Number

Street Address

City

State

ZIP Code

2. PRESCRIPTION DRUG INFORMATION

Drug Name	Strength	Quantity	Date Filled	Rx Number	Amount Paid

Pharmacy Name and Address

3. REASON FOR REIMBURSEMENT REQUEST

Select Reason

If Other, please describe

4. REQUIRED DOCUMENTATION

- Attach the original, itemized pharmacy receipt(s).
- Include prescription label(s) or printout(s) from the pharmacy if available.

5. CERTIFICATION AND SIGNATURE

I certify that the information provided is correct and that the reimbursement requested is for eligible prescription drugs purchased for myself or the indicated member.

Signature

Date