PrescriptionSolutions

Prescription Drug Program
Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s).**

Cash register and credit card receipts alone are not acceptable as proof of purchase.

Reimbursement is not guaranteed.

Claims will be reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (one form per patient)

Health Plan/Insurance Name & State *(please print)*	Group/Employer Name	HIC # Union Trust # (if applicable)
Name *(Last Name, First Name, MI)*	Birth Date	I.D. Number
Mailing Address *(Number, Street, City, State & Zip Code)*		Social Security Number
Prescribing Physician's Name		Physician's Telephone Number

Reason For Request

(At least one must be checked)

- ☐ Out of Area urgent/emergent medication
- ☐ Non urgent medication/vacation request
- ☐ No identification card or identification number available
- ☐ Eligible member/group invalid
- ☐ Coordination of Benefits with Primary Insurance (Complete section below)
- ☐ Referral non-contracted physician/self referral
- ☐ Compound medication
- ☐ Non-contracted pharmacy
- ☐ Other:_______________________________

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription, complete this section.)

Primary Health Plan/ Insurance Company Name ____

Explanation of Benefits must be Attached for Reimbursement Consideration

Primary Member/Subscriber's Name *(Last Name, First Name, MI)*______________________________

Primary Member/Subscriber's ID____

I certify that the patient for whom this claim is made is a covered person in this Prescription Drug Program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder, and/or employer.

X____ ______________________

Member's/Subscriber's Signature Date

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- Pharmacy Name
- Drug name, strength, and quantity
- Prescribing physician's name
- Prescription number and date filled
- Member paid expense

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

Prescription Solutions
ATTN: Claims Department
P.O. Box 6037
Cypress, CA 90630-0037

Reimbursement and correspondence will be issued to the primary member/subscriber.