

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. Please print clearly. Additional information and instructions on back; please read carefully.

RxGroup (see ID card)	ıp (see ID card) Member ID (see ID card)					
Last name	First name	MI				
Mailing street address		Apt. #				
City	State	ZIP				
Prescription is for O Self O Spouse O Dependent	Date of Birth (mm/dd					
Custodial parent information						
For reimbursement requests from a parent for a child (under the age of 1. Parent is not enrolled in the same Group Health plan as the character 2. Parent does not reside in the same household as the subscribe if your child is covered under two or more health plans, state law Legal custodian's name	ild er under the child's Group Health plan	essing claims.				
Custodian requesting reimbursement name						
Address payment is to be mailed to	reimbursement contact phone					
Physician and pharmacy information						
Prescribing physician name	Dispensing pharmacy name					
Prescribing physician phone number with area code	Dispensing pharmacy phone number with area co	de				
Reason for request Select appropriate options for you	ur request					
I did not use my Prescription Drug ID card I used a non-participating pharmacy (please explain)	My primary coverage is with another insurance carrier (coordination of benefits claim; see section C on back for details)					
I filled a compound prescription (your pharmacist must	O I am submitting an Explanation of Benefits (E from another Health Plan or Medicare					
complete section B on the back of this form)	O I am submitting a copay receipt					
I purchased medication outside of the United States	□ I was waiting for a drug approval□ I was retroactively enrolled with the plan					
Country	☐ My pharmacy billed the wrong	olan				
Country Currency used	☐ My pharmacy billed the wrong☐ Other (please explain)					
Acknowledgement I certify that the medication(s) for which reimbursement is and that I (or the patient, if not myself) am eligible for pre	Other (please explain) requested were received for use by the scription drug benefits. I also certify the	ne patient above, nat the medications				
Acknowledgement I certify that the medication(s) for which reimbursement is	Other (please explain) requested were received for use by the scription drug benefits. I also certify the recognize reimbursement will be paid	ne patient above, nat the medications				



Instructions for submitting form

- 1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
- 2. Read the Acknowledgement (section 5) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
- 3. Send completed form with pharmacy receipt(s) to: FutureScripts Claims Department, PO Box 650334, Dallas, TX 75265-0334

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Reimbursement is not guaranteed. Claims are	subject to your plans ilm	its, exclusions and [provisions.				
Section A – Pharmacy receipts for	reimbursement						
Use the following checklist to ensure your rece	eipts have all information	required for your re	eimbursem	ent request:			
□ Date prescription filled□ Name and address of pharmacy□ Prescribing physician name or ID number	☐ National Drug Code☐ Name of drug and st	ug Code (NDC) number ☐ Prescription number (Rx number) ug and strength ☐ Quantity				er)	
Section B – Pharmacy informatio	n (for compound prescr	iptions ONLY)					
(Pharmacist must complete and sign)	D#		Date		Days		
• List VALID 11 digit NDC number (highest to lo			Filled		Supply		
cost) in the box at right. Include EACH ingrediused in the compound prescription.		D 11 digit NDC#		Quantity*	Ingred	Ingredient	

creams, ointments, injectables, etc.

 For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters,

- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.
- * Individual quantities must equal the total quantity.
- [†] Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

L			Filleu							ille	u	Supply			
	VALID 11 digit NDC#									Quantity*		Ingredient Cost [†]			
	Compounding Fee														
	Total														

Section C - Coordination of benefits

Signature of Pharmacist

You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare: If you have not already done so, submit the claim to the Primary Plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

When submitting a copay receipt: If your Primary Plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.

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.*

- *Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.
- *California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

 $Future Scripts\ is\ an\ independent\ company\ that\ provides\ pharmacy\ benefits\ management\ services.$



The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意:如果您說中文 (Chinese),公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通,我们提供一些免费服务,例如用其他语言书写的信件或大字体。您也可以 要求与口译员对话。欲寻求帮助,请拨打您的 ID 卡上列出的免费电话号码。