



## Prescription Reimbursement Form

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. Include copies of pharmacy receipts and register receipts. The pharmacy receipts must include the following:

- Pharmacy Name & Address
- Prescription Number
- Drug Name, Strength & NDC
- Patient's Name
- Fill Date
- Quantity & Days' Supply
- Amount Paid Out-of-Pocket

Mail or fax the completed form with accompanying receipts to:

PharmaForce PBM  
 Attention: Claims Department (DMR)  
 Pharma Force Group LLC  
 1950 Butler Pike, STE 262  
 Conshohocken, PA 19428  
**Fax:** 855-361-0025

**Questions?** Call Customer Service at 877-796-8717.

### Member Information

Member ID \_\_\_\_\_ RxGroup \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M /  F

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Reason for Request

- Prescription Drug ID card not available
- I used a non-participating pharmacy
- Primary coverage is with another insurance carrier
- I was waiting for a drug approval
- Other: \_\_\_\_\_
- I was retroactively enrolled with the plan
- Pharmacy billed the wrong plan
- Emergency fill
- Pharmacy was unable to process claim electronically

### Acknowledgment

I certify that the medications for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

*If not member, must be legal guardian or an Authorized Representative Form is required.*

## Prescription Claim Information

Prescription 1			
Prescription (Rx) Number	Drug Name		Date Filled (MM/DD/YY)
Prescriber's Name	Pharmacy Name	NDC Number	Quantity of Drug
Prescriber's NPI	Pharmacy Number	Total Paid (Cost)	Days Supply

  

Prescription 2			
Prescription (Rx) Number	Drug Name		Date Filled (MM/DD/YY)
Prescriber's Name	Pharmacy Name	NDC Number	Quantity of Drug
Prescriber's NPI	Pharmacy Number	Total Paid (Cost)	Days Supply

  

Prescription 3			
Prescription (Rx) Number	Drug Name		Date Filled (MM/DD/YY)
Prescriber's Name	Pharmacy Name	NDC Number	Quantity of Drug
Prescriber's NPI	Pharmacy Number	Total Paid (Cost)	Days Supply

  

Prescription 4			
Prescription (Rx) Number	Drug Name		Date Filled (MM/DD/YY)
Prescriber's Name	Pharmacy Name	NDC Number	Quantity of Drug
Prescriber's NPI	Pharmacy Number	Total Paid (Cost)	Days Supply