



PRESCRIPTION REIMBURSEMENT FOR

1. Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member.
2. 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

3. Mail or fax the completed form with accompanying receipts to:

PharmaForce
 Attention: Claims Department (DMR)
 PO Box 613
 Columbia, SC 29202
Fax: 866-779-0781

4. Call Customer Service at 833-379-1660 if you have any questions.

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
- I was retroactively enrolled with the plan
- Pharmacy billed the wrong plan
- Emergency fill
- Pharmacy was unable to process claim electronically
- Other: _____

ACKNOWLEDGMENT

I certify that the medication(s) 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 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)
Prescribers 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)
Prescribers Name	Pharmacy Name	NDC Number	Quantity of Drug
Prescriber's NPI	Pharmacy Number	Total Paid (Cost)	Days Supply