



MEMBER COMPOUND REIMBURSEMENT CLAIM FORM

Complete this form, attach prescription labels and mail to:

informedRx

P.O. Box 5206

Lisle, IL 60532- 5206

IMPORTANT!

Do not forget to submit your prescription label receipt(s)

Cardholder Information

Group/Employer/Union Name (REQUIRED):

Cardholder ID#:

Cardholder's Last Name:

First Name:

Middle Initial:

Cardholder's Street Address:

City:

State:

Zip:

Check here if this is a new address or has changed since your last manual claim submission:

Cardholder's Phone Number: () - - @

Cardholder's Email Address:

Number of prescription labels submitted:

Patient Information (one form per patient)

Patient's First and Last Name:

Patient's Date of Birth

Female Male

Patient's relationship to cardholder: Self Spouse Child Other

Reason for Request (check appropriate reason)

- Coordination of benefits with primary pharmacy or medical plan. (Please confirm your plan allows coordination of benefits before submitting)
- Compound claim
- Covered vaccine or vaccine administration fee
- Out of area urgent/emergency request
- Out of area vacation request
- Eligibility issue at the pharmacy
- Other, please describe:

Alternate Insurance/Coordination of Benefits (COB)

Is the prescription(s) covered under any other plan? Yes No

Primary pharmacy or medical plan name: _____

Primary Member/Subscriber's Name: _____

Important - Signature is REQUIRED!

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Date: _____

Cardholder's Signature _____

Special Instructions:

- Complete and return this form when you have purchased a prescription drug and are seeking reimbursement.
- Submit this form with the original prescription label receipt(s) or the pharmacy printout signed by the pharmacist.
- Prescription label receipt obtained from the pharmacy must have the following information clearly legible:
 - Pharmacy name, location and NABP# or NPI#
 - Drug name, NDC#, strength, quantity and day supply dispensed.
 - Prescribing physician's name
 - Total amount paid for the prescription
 - Prescription number and date filled
- Cash register receipts and credit card receipts are not acceptable forms of prescription label receipts.**
- If your plan allows copay reimbursement (COB), please make sure the pharmacy label receipt shows the copay you paid through your primary pharmacy plan.
- All restrictions, exclusions and limits as defined in your plan apply to all claims for direct member reimbursement.
- DO NOT** remove the labels from your medication bottle or box, submit the pharmacy label receipt provided at the time of your purchase.
- INCOMPLETE** forms or prescription label receipts with missing or incorrect information may delay payment or cause the form to be returned to you.
- Please allow 30 days for processing.
- For questions concerning this claim, please call the toll free number listed on your pharmacy ID card.