

# Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.  
An incomplete form may delay your reimbursement.



**medco**<sup>®</sup>

## Member/Subscriber Information *See your prescription drug ID card.*

Group No.

Member ID

Member Name (First, Last) \_\_\_\_\_

Street Address \_\_\_\_\_

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

## Patient Information

Patient Name (First, Last) \_\_\_\_\_

Patient Date of Birth (Month/Day/Year)

Sex Relationship to Plan Member

<input type="checkbox"/> Female	<input type="checkbox"/> 1 Self	<input type="checkbox"/> 5 Disabled Dependent
<input type="checkbox"/> Male	<input type="checkbox"/> 2 Spouse	<input type="checkbox"/> 6 Dependent Parent
	<input type="checkbox"/> 3 Eligible Child	<input type="checkbox"/> 7 Nonspouse Partner
	<input type="checkbox"/> 4 Dependent Student	<input type="checkbox"/> 8 Other

## Pharmacy Information

Name of Pharmacy \_\_\_\_\_

Street Address \_\_\_\_\_

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

Telephone (include area code)

**Is this an on-site nursing home pharmacy?**  Yes  No

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Medco or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

\_\_\_\_\_

Signature of Pharmacist or Representative (Required) NABP Number Required

## Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

\_\_\_\_\_

Signature of Member

## Claim Receipts

Tape receipts or itemized bills on the back.

**See back for details.**

Check the appropriate box if any receipts or bills are for a:

**Compound prescription**  
Make sure your pharmacist lists ALL the VALID NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

**ONE CLAIM FORM  
PER COMPOUND SUBMISSION**

**Medication purchased outside of the United States**

Please indicate:

Country \_\_\_\_\_

Currency used \_\_\_\_\_

**Allergy medication**

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.\*

**Please tape receipts on the back.**

