PRESCRIPTION BENEFIT PROGRAM
MEMBER SELF-PAY REIMBURSEMENT FORM

Cardholder name (Last Name, First Name, M.I.)________________________________________________________________________ Date: __/__/____
Cardholder ID# (from ID card)_________________________________________ Member# (from ID card)__________________________
Patient Name (Last Name, First Name, M.I.)_________________________________________ DOB: __/__/____
Patient’s Sex:  □ Male  □ Female  Relationship of Patient to Cardholder:  □ Self  □ Spouse  □ Child  □ Other
Cardholder’s Mailing Address__________________________________________ City:___________ State ___ Zip______
Employer Name (If applicable)__________________________________________ Group Name__________________ Group#_______

I CERTIFY THAT THE PATIENT FOR WHOM THIS CLAIM IS MADE IS A COVERED PERSON IN THIS BENEFIT PROGRAM AND THAT THESE PRESCRIPTIONS ARE FOR THE SOLE USE OF THE NAMED PATIENT. I ALSO CERTIFY THAT THE CLAIM(S) BEING SUBMITTED FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT AUTOMOBILE OR WORKER’S COMPENSATION PROGRAM.

(Cardholder/Authorized Representative Signature): X_________________________ Telephone No: ________________

PRESCRIPTION INFORMATION

CLAIM #1   □ New □ Refill
RX Number:_______________ Date Filled: __/__/_____ Days Supply:_____________ Metric Qty Dispensed____
Name of Drug (if generic include manufacturer)______________________________________________ Strength_____ Dosage_____
**If compounded Rx, see instruction #5.
National Drug Code:
Rx Price (including discounts) $_____ Manufacturer__ __ __ __ __   Product # __ __ __ __ __   PKG __ __
Name of Prescribing Physician or ID Number (ie DEA #/NPI)_____________________________________________

CLAIM #2   □ New □ Refill
RX Number:_______________ Date Filled: __/__/_____ Days Supply:_____________ Metric Qty Dispensed____
Name of Drug (if generic include manufacturer)______________________________________________ Strength_____ Dosage_____
**If compounded Rx, see instruction #5.
National Drug Code:
Rx Price (including discounts) $_____ Manufacturer__ __ __ __ __   Product # __ __ __ __ __   PKG __ __
Name of Prescribing Physician or ID Number (ie DEA #/NPI)_____________________________________________

Y0110_MbrReimForm IA 09/30/2016
Please read instructions prior to completing this form.
INSTRUCTIONS

A. WHEN TO USE THIS FORM

This claim form is to be used only when it has been necessary to purchase prescriptions because your participating pharmacy did not honor your identification card or was unable to directly submit your claim. It should also be used when it was necessary to have your prescriptions filled at a non-participating pharmacy.

Submit this form to the address below as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to keep the form until completely filled.

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under Cardholder Information. Transfer the Cardholder Identification Number, Member Number (if applicable) and Group Number from your identification card. This section must be fully completed to ensure proper reimbursement of your claim. Claims with missing or illegible information will be returned delaying payment.

2. A separate claim form must be completed for each patient.

3. Have your pharmacist complete the PRESCRIPTION INFORMATION section for each prescription filled and the PHARMACY INFORMATION section. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or your receipt.

IMPORTANT: The drug quantity, drug name and strength or eleven digit National Drug Code (NDC) is required and must appear on your submitted claim(s) or receipt(s).

4. The original paid pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory proof of purchase.

5. FOR COMPOUNDED PRESCRIPTIONS ONLY: If your pharmacist tells you this is a compounded prescription, you must complete CLAIM NUMBER 4. Ask your pharmacist for assistance. The NDC number appearing on the claim should be that of the most expensive prescription ingredient. Should you have more than one compounded prescription, please use additional claim forms.

6. Claim forms submitted without the required information can cause payment delays and result in the information being returned for completion.

C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to:

   Envision/Rx Options, Inc.
   2181 East Aurora Road Suite 201
   Twinsburg, Ohio  44087

2. Keep a copy of all documents submitted for your records.

3. Please allow up to 30 days from the time you send this form for processing and payment of your claims.

4. You may call 844-860-6750, seven (7) days a week, 24 hours a day. TTY/TDD users should call 711 for questions or problems concerning your submitted claims.