

**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) \_\_\_\_\_

**CLAIM #3**    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 #4 – Compounded Prescription Claim**    New   Refill

RX Number: \_\_\_\_\_ Date Filled: \_\_\_/\_\_\_/\_\_\_ Days Supply: \_\_\_\_\_ Metric Qty Dispensed \_\_\_\_\_

Compounded Ingredients/Quantities \_\_\_\_\_

**National Drug Code:**

Rx Price (including discounts) \$ \_\_\_\_\_ Manufacturer \_\_\_\_\_ Product # \_\_\_\_\_ PKG \_\_\_\_\_

Name of Prescribing Physician or ID Number (ie DEA #/NPI) \_\_\_\_\_

**Pharmacy Information:**

Name of Pharmacy: \_\_\_\_\_ Telephone No. \_\_\_\_\_

Address: \_\_\_\_\_ NABP Pharmacy ID: \_\_\_\_\_

I CERTIFY THAT THE CHARGE SHOWN IS FOR THE DRUG(S) DISPENSED TO THIS RECIPIENT. (Signature and License # of Pharmacist)

X \_\_\_\_\_ License # \_\_\_\_\_ Date: \_\_\_\_\_

**Additional Prescription Insurance Coverage:**

Do you have any other prescription insurance?   Yes                      No  
If yes, select coverage:                      Primary                      Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_

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.