ENVISION Rx OPTIONS

MEMORIAL HERMANN Health Plan
MEMORIAL HERMANN *ADVANTAGE* HMO

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.

Rx Price (including discounts) $____ **National Drug Code**: 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.

Rx Price (including discounts) $___ **National Drug Code**: 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.

Rx Price (including discounts) $___ **National Drug Code**: 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_____

Rx Price (including discounts) $___ **National Drug Code**: 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?
If yes, select coverage:

☐ Yes ☐ No
☐ 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:

   EnvisionRx 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.

Memorial Hermann *Advantage* HMO is provided by Memorial Hermann Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in this plan depends on contract renewal.

Memorial Hermann *Advantage* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.645.8448 (TTY 711).