PHARMACARE

Prescription Drug Program Direct Member Reimbursement Form

Member Information

Employer Name	Group Name	Group Number
Member Name (Last Name, First Name)	Member I.D. Number	Daytime Phone Number

Patient's Name (Last Name, First Name)	Patient's Sex	Relationship of Patient to Member	Date of Birth
	❑ Male ❑ Female	❑ Self ❑ Spouse ❑ Child ❑ Other	

Mailing Address of Member	Number and Street	City	State	Zip Code

I CERTIFY THAT THE PATIENT FOR WHOM THIS CLAIM IS MADE IS A COVERED PERSON IN THIS PRESCRIPTION DRUG PROGRAM AND THAT THE PRESCRIPTION IS 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 WORKERS' COMPENSATION INSURANCE PROGRAM.

(Member/Authorized Representative) _____

PLEASE READ ALL INSTRUCTIONS

We will only accept a FULL PRINTOUT (a full printout with name of medication(s), quantity, days supply, strength, NDC number, date and pharmacy information) from the pharmacist, or the ORIGINAL ATTACHED RECEIPT that was on your medication bag at time of purchase. The cash register receipt is **NOT** satisfactory evidence of purchase.

This form and FULL PHARMACY PRINTOUT or this form and the ORIGINAL ATTACHED RECEIPT(S) **must be mailed to:**
PharmaCare P.O. Box 2860 Pittsburgh, PA 15230-2860

IMPORTANT INFORMATION ABOUT YOUR SUBMITTED CLAIM

* Will only reimburse at the retail day supply allowance.
* Will only be reimbursed for medications covered under the plan or medications that already have been authorized.
* Submit this form for reimbursement because it was necessary to purchase a prescription when you did not have your identification card or because the pharmacy where your prescription was filled is a non-participating pharmacy. (Plan specific, please check individual plans).
* Submit a separate claim form for each patient.
* Submit this form as soon as you have your prescription(s) filled. Claims may not be reimbursed after one year.
* Claim forms submitted without the required information will cause payment delays or may be returned to you.
* If you have any questions or concerns regarding your claim, please call the toll-free telephone number on your prescription identification card.

FOR COMPOUND PRESCRIPTIONS ONLY

If your pharmacist tells you this is a compounded prescription, have your pharmacist complete the area below. Should you have more than two compounded prescriptions, please use additional forms.

Claim #	NDC #	Compound Ingredients Drug Names	Qty	Cost

PRIVACY NOTICE: We will use the address provided above to send your reimbursement, even if contrary to any confidential communications instructions you may have on file with PharmaCare. If you desire this reimbursement to be sent to a confidential address that has previously been communicated to PharmaCare, please indicate that address on this form. In any case, the address that you provide here will be used only for mailings related to this Direct Member Reimbursement.