

# Prescription Drug Reimbursement Form

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



## Customer Information *See your ID card.*

Group No. **UHEALTH**

Customer ID

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

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

City  State  Zip

## Patient Information

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

Patient Date of Birth (Month/Day/Year)

Sex *Relation to Plan Customer*

<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 Other
	<input type="checkbox"/> 4 Dependent Student	<input type="checkbox"/> 8 Non-Spouse Partner

## Pharmacy Information

Name of Pharmacy \_\_\_\_\_ NABP Number

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

City  State  Zip

Telephone (include area code)

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

If yes, I hereby certify that the charge(s) shown for the medications prescribed is (are) correct and agree to provide Medco Health 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 customer and assignment of these benefits to a pharmacy or any other party is void.

**X** \_\_\_\_\_  
Signature of Pharmacist or Representative (Required)

## Claim Receipts

Tape claim receipts or itemized bills on the back. **Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

- is a compound prescription.**  
Make sure your pharmacist lists ALL the 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.**
- was purchased outside the U.S.A.**  
If so, please indicate:  
Country \_\_\_\_\_  
Currency used \_\_\_\_\_
- is for treatment of an allergy.**

**Please tape receipts on the back**

## Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for 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.

**X** \_\_\_\_\_  
Signature of Customer

