Manual Member Reimbursement Form

Instructions:

- The purpose of this form is to request reimbursement for your medication purchased without using your health plan card or other reasons approved by your health plan.
- In order to process your request within 30 business days after receiving your request, it is important to complete all of the information and documentation requested.
- Please use a separate form for each patient.
- In some instances, it will be necessary to contact the pharmacist to assist in completing the information required by the Pharmacy.
- Your health plan will determine reimbursement due based on your Pharmacy benefit.
- Reimbursements are subject to the terms and conditions of your health plan and the amount may be less than the amount presented less applicable copay.
- Reimbursement will only be considered within the timeframe established by your health plan

Patient Information
Contract Number:
Group Number:
Patient Name:
Date of Birth:
Patient Address:
Patient Telephone Number:
Name of Legal Representative (If applicable):

_____
Print Name

_____
Signature

Date: _____

Pharmacy Section:

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name	**Physician NPI**		**Total Paid**

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name	**Physician NPI**		**Total Paid**

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name	**Physician NPI**		**Total Paid**

Pharmacy NABP	**Rx Number**	**Date Dispensed**	**Quantity**
Day Supply	**Drug Name & Strength**		**Drug NDC (11 digits)**
Physician Name	**Physician NPI**		**Total Paid**

In order to process your request for reimbursement for your medication, it is necessary that you include the following documents:

- Copy of your prescription (recommended)
- If you are unable to complete the information “Pharmacy Section”, please include the original copy of your receipt:

  - ❖ Drug Name, dose & quantity dispensed
  - ❖ Prescription Number
  - ❖ National Drug Code (NDC)
  - ❖ Amount Paid for the medications
  - ❖ Date Dispensed
  - ❖ Name, Address, Telephone & Pharmacy NPI#
  - ❖ Name & Physician NPI# that prescribed the medication

- Include cash register receipt.

If you have any questions, please contact our customer service center at the number shown on your ID card.

Remember to sign the manual reimbursement form and send via email or fax to the following address:

info@pcarx.com
Fax: 1-844-722-7948