Direct Member Reimbursement Form

Please Mail or Fax form and copy of purchase receipt to:

Mailing Address: 6412 N. University Drive, Suite 113, Tamarac, FL 33321
Fax Number: 754-800-7622

_____
Employer

_____	_____	_____	_____
Your Last Name (Please Print)	*First Name*	*Middle Initial*	*Member ID*

_____	_____	_____	_____
Your Home Address	*City*	*State*	*Zipcode*

_____	_____	_____	_____
Pharmacy / NABP # (if available)	*Days Supply*	*Quantity Dispensed*	*NDC (If Available)*

Date Dispensed _____

Proof of Purchase (Prescription Purchase Receipt): Attach copies of purchase receipts.

Only purchases for covered prescriptions under your benefit plan are eligible for reimbursement. The eligible reimbursement amount is up to the network contracted amount less applicable copay under the benefit plan.

_____
Print Name

_____ _____

Signature *Date*