Direct Member Reimbursement Form

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

Mailing Address: 6412 N. University Drive, Suite 113, Tamarac, FL 33321
Or Fax to 888-389-9668

_____ _____
Employer *Patient Name*

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

_____ _____ _____ _____
Employee Home Address *City* *State* *Zip Code*

_____ _____ _____ _____
Pharmacy Name and Phone number *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*