Direct Member Reimbursement Form

<u>(Please send to US-Rx Care within 1 week of purchase)</u>

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

Mailing Address: 4600 Sheridan Street, Suite 200, Hollywood, FL 33021
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* *Drug name and strength*

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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.

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Print Name

_______________________________________ ____________________________
Signature *Date*