DIRECT MEMBER REIMBURSEMENT FORM

Please Mail or Fax this form and copy of purchase receipt within 14 days of purchase to:

Mailing Address: 4600 Sheridan Street, Suite 200, Hollywood, FL 33021
Fax: 888-389-9668

_____ _____
Employer *Patient Name*

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

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

_____ _____ _____ _____
Pharmacy Name and Phone # *Day Supply* *Quantity Dispensed* *NDC (If available)*

Date Dispensed _____

Proof of Purchase (Prescription Purchase Receipt): Attach copies of your pharmacy printout that includes drug name, strength, and NDC, and your payment receipt.

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*

US-Rx Care
4600 Sheridan Street, Suite 200
Hollywood, FL 33021