



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