



DIRECT MEMBER REIMBURSEMENT FORM

Please mail or fax this form, along with a copy of your proof of purchase as described below, within 7 days of purchase.

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

<i>Employer</i>		<i>Patient Name</i>	
<i>Employee Last Name (Print)</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Member ID</i>
<i>Employee Home Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Pharmacy Name and Phone #</i>	<i>Day Supply</i>	<i>Quantity Dispensed</i>	<i>NDC (If Available)</i>
<i>Date Dispensed</i>			

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.

<i>Print Name</i>	
<i>Signature</i>	<i>Date</i>