



PRESCRIPTION REIMBURSEMENT CLAIM FORM

Please print.

SECTION I - CARDHOLDER / MEMBER INFORMATION

Employer/Health Plan Name: _____

Group Number: _____

ID Number: _____

Cardholder/Member Name (First, Last) _____

Street Address _____

City _____ State _____ Zip _____

I certify that all information on this claim form is accurate. I also certify that the patient for whom this claim is made is a covered person in this prescription drug program and that the prescription is for the sole use of the named patient. I understand that **Serve You's** use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability Accountability Act of 1996).

Cardholder/Member Signature _____

Do you have other insurance for prescription medications? Yes No

If yes, who? _____

Coordination of Benefits (COB) claims are processed only if allowed by your benefit plan. If filing COB claims, please include an Explanation of Benefits (EOB) from the primary insurance carrier indicating the portion of benefits paid.

SECTION II - PATIENT INFORMATION

Patient Name (First, Last) _____

Date of Birth ___/___/___ Male Female

Patient's Relationship to Cardholder/Member:

Self Spouse Dependent

SECTION III - PRESCRIPTION INFORMATION

Receipts must contain the following information:

- Prescription Number
 - Date Filled
 - Name of Medication
 - NDC (National Drug Code)
 - Quantity
 - Days Supply
 - Amount Paid
- Please refer to Section V for a sample receipt.*

Attach Prescription Receipt Here

DO NOT STAPLE

If the information below is not on the receipt, please fill this in. Ask your pharmacist for assistance if needed.

NDC#: _____

Days Supply: _____

Attach Prescription Receipt Here

DO NOT STAPLE

If the information below is not on the receipt, please fill this in. Ask your pharmacist for assistance if needed.

NDC#: _____

Days Supply: _____

Use a separate sheet of paper if you have more receipts.

SECTION IV - COMPOUNDS

Compound prescriptions require your pharmacist to complete the following information:

List all ingredients and quantity dispensed for this prescription.

Ingredient Name	Strength	Qty.

Active Ingredient: _____

Pharmacist Signature _____ Date _____

Attach Prescription Receipt Here

DO NOT STAPLE

If the information below is not on the receipt, please fill this in. Ask your pharmacist for assistance if needed.

NDC#: _____

Days Supply: _____

SECTION V - SAMPLE RECEIPT

(Serve you.) 9051 W. Heather
P.O. Box 240034
1-800-759-3203 Milwaukee, WI 53224-9002

Rx #00319739 12/04/03
PATIENT TEST
9051 W HEATHER AVE MILWAUKEE, WI
CVG: CSH MRN: _____

30 ACETAMINOPHEN TAB 500MG 00677-1140-01
URL DR. C. TEST
3 Refills of 30

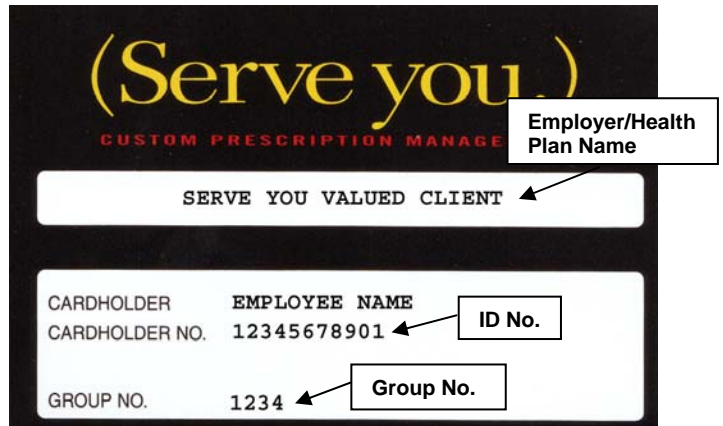
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

Callouts: Prescription No., Date Filled, Name of Medication, NDC, Amount Paid, Qty.

SECTION VI - INSTRUCTIONS

You must provide all information requested in order for this claim to be considered for reimbursement.

The Group Number and ID Number can be found on your **Serve You ID Card** or listed on your Medical ID Card.



- **Incomplete claim forms will be returned unprocessed.**
- Contact your pharmacist, if necessary, to assist you in completing this claim form.
- Complete a separate form for each family member for whom prescription drugs were purchased.
- If submitting more than two claims, please use another claim form.
- Claims must be submitted within 1 year of date of purchase or as required by your plan.
- Mail completed claim form and prescription receipts to:

**Serve You
Member Reimbursement
P.O. Box 26096
Milwaukee, WI 53226-0096**

If you have any questions, please call:

Serve You Member Services at 1-800-759-3203

Hours of Operation:

Monday – Friday: 7:30 a.m. – 9:00 p.m. CST
Saturday : 8:00 a.m. – 6:00 p.m. CST
Sunday : 9:00 a.m. – 3:00 p.m. CST

If additional claim forms are needed, please make a copy of this form or download from our website:

www.serve-you-rx.com