SERVE YOU Rx DIRECT

# Prescription Reimbursement Claim Form

## SECTION I – CARDHOLDER/MEMBER INFORMATION

EMPLOYER/HEALTH PLAN NAME

GROUP NUMBER

ID NUMBER

CARDHOLDER/MEMBER NAME (FIRST, LAST)

STREET ADDRESS

CITY ST ZIP CODE

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 Rx'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 (MM/DD/YY)

☐ 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#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

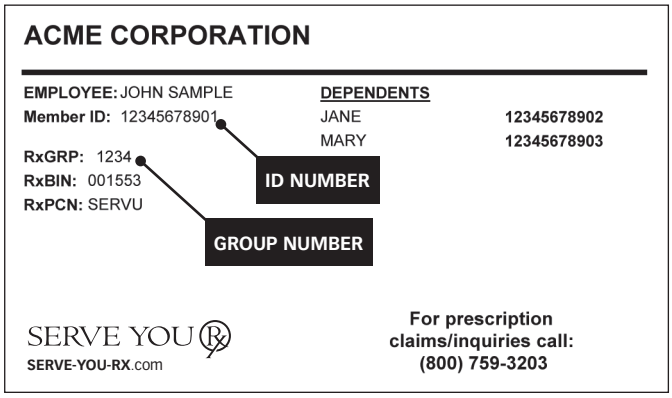
Days Supply:_____

## SECTION V – SAMPLE RECEIPT


## SECTION VI – INSTRUCTIONS

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

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




**Incomplete claim forms will be returned unprocessed.**

- If necessary, contact your pharmacist 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.
- Send completed claim form and prescription receipts to:

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

  **Fax:** 414-410-8181

  **Email:** customerservice@serve-you-rx.com

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL:**
Serve You Rx Customer Service at
**800-759-3203**

**HOURS OF OPERATION:**
Monday – Friday: 7:30 a.m. – 9 p.m. CST
Saturday: 8 a.m. – 6 p.m. CST
Sunday: 9 a.m. – 3 p.m. CST

If additional claim forms are needed, please make a copy of this form or download from our website:
**serve-you-rx.com**

SERVE YOU Rx
**SERVE-YOU-RX**.com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