# Prescription Drug Reimbursement Form

To request reimbursement for any covered prescription drug that you purchased, please submit this form along with:

- Original prescription label receipts
- Physician-generated receipts (for vaccine and vaccine administration requests only)

*Please note that we cannot accept cash register or credit card receipts alone as proof of purchase.*

This form is not a guarantee of coverage. Claims are reviewed and subject to plan benefit provisions, including limitations and exclusions.

## PATIENT INFORMATION

Name *(Last, First, MI)*:______________________________ Birth Date:______________

PUP ID Number:______________________________ Member Phone Number:_____-_____-________

Mailing Address *(Number, Street, City, State, Zip Code)*:______________________________

__________________________________________________________________

Prescribing Physician's Name:______________________ Physician's Phone Number:_____-_____-________

## REASON FOR REQUEST

☐ Out of area urgent / emergency medication

☐ Non urgent medication / vaccination request

☐ No ID card or ID number available

☐ Coordination of Benefits (from primary insurance - complete section below)

☐ Compound medication

☐ Non-contracted pharmacy

☐ Other:______________________________

## IF THIS REQUEST IS FOR COORDINATION OF BENEFITS, PLEASE FILL OUT THIS SECTION

*If your primary insurance has already paid for this prescription or vaccination in whole or in part, please complete this section.*

Primary Insurance Company Name:______________________________

Primary Member / Subscriber's Name (Last, First, MI):______________________________

Primary Member / Subscriber's ID:______________________________

## IF THIS REQUEST IS FOR VACCINATION, PLEASE FILL OUT THIS SECTION

*Itemized Physician-generated receipts are acceptable for vaccines and vaccine administration only.*

***Proof of payment must be included.***

☐ Filled at pharmacy, and administered at physician's office

☐ Filled and administered at pharmacy

☐ Filled and administered at physician's office

**Check below all that apply to the cost of the claim**

☐ Vaccine and administration cost

☐ Vaccine cost

Prescription label receipt must have the following information clearly legible or reimbursement may be delayed. Physician receipt must have the items listed with an asterisk or reimbursement may be delayed.

- Pharmacy name
- Drug name*, strength, and quantity*
- Prescribing physician's name*
- Prescription number
- Date filled*
- Proof of payment by member*

I certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or worker's compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan.

Member Signature:______________________________ Date:________________

**Please mail label receipt(s) and this completed and signed form to:**
**Partners Rx Management, P.O. Box 12119, Scottsdale, AZ 85260**

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