

# PRESCRIPTION DRUG PROGRAM DIRECT MEMBER REIMBURSEMENT FORM

## Instructions

1. Complete and return this form when you have purchased a covered and prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription/label receipts to expedite processing.** A cash register receipt alone is not acceptable as proof of purchase.
2. Prescription receipt/labels must have the following information clearly legible, or payment can be delayed or denied:
  - Pharmacy name
  - Prescription number and date filled
  - Prescribing physician's name
  - Drug name, strength and quantity
  - Member expense
3. This claim will be returned if the member/subscriber signature is not present.
4. Please mail these receipts/labels and this completed form to the address at the bottom of the form.
5. All payments and correspondence will be issued to the primary member/subscriber.

| Patient Information (one form per patient)                          |                     |                               |
|---|---------------------|-------------------------------|
| Health Plan/Insurance Name & State <i>(please print)</i>            | Group/Employer Name | Union Trust # (if applicable) |
| Name <i>(Last Name, First Name, MI)</i>                             | Birth Date          | ID #/HIC #                    |
| Mailing Address <i>(Number, Street, City, State &amp; Zip Code)</i> |                     | Social Security #             |
| Prescribing Physician's Name  |                     | Physician's Telephone Number  |

| Reason for Request (at least one must be checked)   |  |
|---|--|
| <input type="checkbox"/> Out-of-Area urgent/emergency medication<br><input type="checkbox"/> Non-urgent medication/vacation request<br><input type="checkbox"/> No identification card or identification number available<br><input type="checkbox"/> Eligible member/group invalid<br><input type="checkbox"/> Coordination of Benefits (with primary insurance) | <input type="checkbox"/> Referral or non-contracting physician/self-referral<br><input type="checkbox"/> Compound medication<br><input type="checkbox"/> Non-contracted pharmacy<br><input type="checkbox"/> Other _____ |

| Coordination of Benefits (if your primary insurance has already paid for the attached prescription, please complete this section)  |  |                 |
|--|--|-----------------|
| Primary Health Plan/Insurance Company  | Spouse's Name <i>(Last Name, First Name, MI)</i> | Spouse's Number |
| <p>I 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 also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or workers' compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder and/or employer.</p> |  |                 |
| X _____<br>Member's/Subscriber's Signature   |  | _____<br>Date   |

**Prescription Solutions**  
 Mail Stop LC07-290  
 Attn: Claims Dept.  
 P.O. Box 6037  
 Cypress, CA 90630-0037

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