Direct Member Reimbursement Form

Please Mail or Fax form and copy of purchase receipt to:

Mailing Address:

4600 Sheridan Street, Suite 200, Hollywood, FL 33021

Fax Number: 888-389-9668

_____
Employer

_____ _____ _____ _____
Your Last Name (Please Print) *First Name* *Middle Initial* *Member ID*

_____ _____ _____ _____
Your Home Address *City* *State* *ZIP Code*

_____ _____ _____ _____
Pharmacy / NABP # (if available) *Days Supply* *Quantity Dispensed* *NDC (If Available)*

Date Dispensed _____

Proof of Purchase (Prescription Purchase Receipt): Attach copies of purchase receipts.

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.

_____
Print Name

_____ _____
Signature *Date*