Direct Member Reimbursement

For OTC COVID-19 test kit reimbursement, complete the top of the form including the signature.

CARDHOLDER INFORMATION

Cardholder ID# RxGRP # Plan Sponsor

Cardholder Name Phone

MEMBER INFORMATION

Complete this section only if the claim is for a spouse or dependent, not the primary cardholder.

Member Name

Relationship: ☐ SPOUSE ☐ CHILD ☐ OTHER

SIGNATURE / RELEASE

By signing this form, you certify that the information provided is accurate and authorize the release of all necessary information to all appropriate parties involved in the administration of this claim. All medications described herein were received by the named patient, and he/she is eligible for benefits. None of the named medications described herein are covered under another benefit plan or for an on-the-job injury.

Signature (Member, Parent or Guardian) Print Name Date

PRESCRIPTIONS FOR REIMBURSEMENT

If you have receipts, enclose them with this form. If you enclose your receipts, there is no need to complete the bottom of this form. Be sure your itemized receipts include the following: 1) Pharmacy Name 2) Pharmacy NABP# 3) Prescription Number 4) Date of Purchase 5) Total amount charged for each prescription 6) Medicine Name 7) Strength 8) Quantity Dispensed.

If you don't have receipts, ask your pharmacist for a copy or to complete and sign the bottom of this form.
Pharmacist: By signing this form, you certify that the information on the form below correctly represents the amount charged and the prescriptions dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member.

Signature (Pharmacist or Pharmacy Representative) Print Name Date

Prescription #1

Rx Number	Date Filled	NDC#	Medicine

Strength | Day Supply | Quantity

☐ New ☐ Refill ☐ DAW ☐ Compound

Prescribers DEA# | Pharmacy NABP# | $ Total Cost

Approval (INTERNAL USE ONLY)

Prescription #2

Rx Number	Date Filled	NDC#	Medicine

Strength | Day Supply | Quantity

☐ New ☐ Refill ☐ DAW ☐ Compound

Prescribers DEA# | Pharmacy NABP# | $ Total Cost

Approval (INTERNAL USE ONLY)

Prescription #3

Rx Number	Date Filled	NDC#	Medicine

Strength | Day Supply | Quantity

☐ New ☐ Refill ☐ DAW ☐ Compound

Prescribers DEA# | Pharmacy NABP# | $ Total Cost

Approval (INTERNAL USE ONLY)

OVER

COMPOUNDS

To be completed by your pharmacist if the prescriptions being submitted for reimbursement are compound medications, even if you have itemized receipts:

NDC#	INGREDIENT	QUANTITY	COST

Pharmacist signature:_____

INSTRUCTIONS

- Copy the Cardholder ID number and Group number (RxGRP) from your ID card.
- Your Plan Sponsor is your employer or the organization through which you receive benefits.
- Be sure to read the release, and to sign and date this form to certify accuracy of the information provided.
- Retain copies of all documentation. Forms and receipts submitted to EmpiRx Health will not be returned.

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan and only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Be sure you have completed the form accurately and included the following for each prescription to be reimbursed. If you do not have the details or an itemized receipt, your pharmacist can assist you in completing the form. Have your pharmacist sign the front of the form if they assist you in completing it. If you are submitting a compound prescription for reimbursement, have your pharmacist complete and sign the top of this page, even if you do have an itemized receipt.

- Your prescription #
- Date of purchase
- Prescription NDC#
- Name of medicine
- Strength of the prescription
- Day supply
- Quantity
- Prescriber DEA#
- Pharmacy NABP#
- Prescription number
- Total cost for each prescription

Items not covered under your prescription benefit plan should not be submitted for reimbursement, including Durable Medical Equipment. Diabetic supplies requiring a prescription are reimbursable only if covered by your plan. Canceled checks and cash register receipts are not acceptable forms of receipts to be submitted for reimbursement.

Fraud Prevention - Any person who knowingly, and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a fraudulent insurance act, which is a crime, and subjects such a person to criminal and civil penalties.

MAIL COMPLETED FORM TO:

EmpiRx Health
PO Box 1339
Mechanicsburg, PA 17055
Email to: C19_DMR@benecardpbf.com

QUESTIONS

If you have any questions, please contact EmpiRx Health Member Services at
the phone number on the back of your ID card,
24 hours a day, 365 days a year.
www.empirxhealth.com