

PDP Prescription Drug Program Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s) within 90 days.**

Cash register and credit card receipts alone are not acceptable as proof of purchase.

Reimbursement is not guaranteed.

Claims will be reviewed, subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (one form per patient)

Health Plan/Insurance Name & State <i>(please print)</i>	Group/Employer Name	HIC Number
Name <i>(Last Name, First Name, MI)</i>	Birth Date	I.D. Number
Mailing Address <i>(Number, Street, City, State & Zip Code)</i>		Social Security Number
Prescribing Physician's Name		Physician's Telephone Number

Reason For Request

Write reason here:

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription, please complete this section.)

An Explanation of Benefit from the primary insurance must include the dollar amount paid by the primary insurance.

Primary Health Plan/ Insurance Company Name _____

Primary Member/Subscriber's Name *(Last Name, First Name, MI)* _____

Vaccine and Vaccine Administration

<input type="checkbox"/> Filled at pharmacy, and administered at physician's office <input type="checkbox"/> Filled and administered at pharmacy <input type="checkbox"/> Filled and administered at physician's office	Check below all that apply to the cost of the claim <input type="checkbox"/> Administration Cost <input type="checkbox"/> Vaccine Cost
---	---

Compound Prescriptions Only (Pharmacist signature required)

- List the VALID 11 digit NDC number (highest to lowest cost) in the box at the right for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be provided with claim form

Rx#	Date Filled	Days' Supply	
			Total Quantity
			Total Charge

Valid 11 digit NDC#	Quantity

Signature of Pharmacist X _____

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 worker's 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.

Member's/Subscriber's Signature X _____ **Date** _____

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- | | |
|--|--|
| <ul style="list-style-type: none"> ● Pharmacy Name ● Drug name, strength, and quantity ● Prescribing physician's name | <ul style="list-style-type: none"> ● Prescription number and date filled ● Member paid expense |
|--|--|

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

**Prescription Solutions
P.O. Box 29046
Hot Springs, AR 71903**

Reimbursement and correspondence will be issued to the primary member/subscriber.