MEMBER REIMBURSEMENT CLAIM FORM

Please mail this claim form directly to:

informedRx Manual Claims
P.O. Box 3163
Lisle, IL 60532-8163

For assistance please call:
(8 0 0) 482 - 1285
For the hearing impaired call:
TTY (866) 261- 0791
24 hours a day, 7 days a week

Please print or type this information

Group# | | | | | | | | I.D. # | | | | | | | | | | | | | | | |

Plan/Employer Name: (**REQUIRED**)

Cardholder's Last Name: First Name: Middle Initial:

Cardholder's Street Address: City: State: Zip:

( ) — Cardholder's Day Time Phone Number: ( ) — Cardholder's Evening Phone Number:

Patient's Name: (Use a separate claim form for each covered family member) Patient's Date of Birth / /

☐ Female ☐ Male
Patient's Gender

☐ Self ☐ Spouse ☐ Child ☐ Other
Patient's relationship to cardholder

WITHOUT PHARMACIST SIGNATURE - PHARMACY LABEL RECEIPTS ARE REQUIRED

1 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | |

Pharmacy NPI | | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx ☐ Vaccine

Vaccine Administration Fee you Paid (if any) $ _____

2 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | |

Pharmacy NPI | | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx ☐ Vaccine

Vaccine Administration Fee you Paid (if any) $ _____

CLAIM WILL BE RETURNED IF REQUIRED INFORMATION IS MISSING

Date: _____ Cardholder's Signature _____

Date: _____ Pharmacist's Signature _____

I certify that all information on this claim form is accurate. I understand that informedRx, Inc.'s use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

MEMBER REIMBURSEMENT CLAIM FORM (CONTINUED)

Group # | | | | | | | | ID # | | | | | | | | | | | | | | | |

WITHOUT PHARMACIST SIGNATURE - PHARMACY LABEL RECEIPTS ARE REQUIRED

3 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | | Pharmacy NPI | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx ☐ Vaccine

Vaccine Administration Fee you Paid (if any) $ _____

4 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | | Pharmacy NPI | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx ☐ Vaccine

Vaccine Administration Fee you Paid (if any) $ _____

5 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | | Pharmacy NPI | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx ☐ Vaccine

Vaccine Administration Fee you Paid (if any) $ _____

6 Fill date _____ RX#_____ Quantity _____ Day Supply _____

Drug Name _____

NDC # | | | | | | | | | | | | Pharmacy NPI | | | | | | | | | |

Pharmacy Address & Phone Number

Amount You Paid. $ _____ ☐ Full Price ☐ Co-Pay

☐ Compound ☐ Regular Rx ☐ Vaccine

Vaccine Administration Fee you Paid (if any) $ _____

CLAIM WILL BE RETURNED IF REQUIRED INFORMATION IS MISSING

Cash register receipts are not accepted. Please make copies for your records - documents will NOT be returned.

Questions? Call (8 0 0) 4 8 2 - 1 2 8 5

For the hearing impaired call TTY (866) 261-0791