

This form should be used to obtain reimbursement for prescription(s) purchased without your drug card. For reimbursement consideration, please complete all three sections below. Claims received more than 90 days from date of fill will not be reimbursed.

Claims are reimbursed at UM pharmacy network **contracted price** minus your co-pay

1

Member ID No: U Name: _____, _____, _____
 (Can be found on your ID card) (First) (Last) M.I.
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Plan Name: _____ Group No: _____

Do you have Other insurance? _____ Other Insurance Company Name: _____
 Other Insurance Member Number: _____ Amount Paid \$ (Receipts must be attached) _____

Remember...
 ✓To avoid delays, make sure all information is complete and correct. Please type or print clearly!
 ✓A separate claim must be completed for each patient and for each pharmacy.

IMPORTANT
 I certify that all information on this claim form is accurate. I also 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 understand that SXC Health Solutions, 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).

Signature: _____ **Date:** _____

2

PATIENT INFORMATION:
 Name: _____, _____, _____ Date of Birth: ____/____/____
 (First) (Last) M.I.
 Gender: _____ Relationship to Cardholder: _____
 (Male/Female) (Self/Spouse/Child/Other)

PRESCRIPTION INFORMATION (Have your pharmacy complete any missing information.)

U-M Prescription Plan will pay for Compounded medications if all of the following criteria are met:

- A. The product contains at least one covered active prescription ingredient **and**
- B. The prescription active ingredient(s) is FDA-approved for medical use in the United States via the same route of administration **and**
- C. The compounded product is not a copy of commercially available FDA-approved drug product **and**
- D. The safety and effectiveness of use for the prescribed indication is supported by FDA-approval or adequate medical and scientific evidence in the medical literature.

3

Pharmacy ID (NABP/NPI) No: _____ **Pharmacy Name:** _____
 (Can be found on either your receipt or Prescription)
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Prescription No.: _____ **Date Filled:** _____ **Final Route of Administration:** _____
Final Dosage Form: _____

<u>NAME</u>	<u>NDC</u>	<u>QUANTITY</u>	<u>COST</u>

Remember...
 ✓ Most information above can be obtained from the Prescription label(s) and/or receipts(s).
 ✓ Include original paid pharmacy receipt(s) only – cash register receipts are not allowed!
 ✓ Please make copies of all documents and original paid pharmacy receipt(s) – documents will not be returned to you
 ✓ For additional reimbursement of prescriptions from the same pharmacy, please attach additional copies of this form.

After completing all sections above, please mail this form and paid pharmacy receipt(s) to:

SXC Health Solutions, Inc. -Attn: Interactive Services- 8444 North 90th St. Ste 100, Scottsdale, AZ 85258