

**PRESCRIPTION DRUG  
 REIMBURSEMENT FORM**

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

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**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)

3

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

**Pharmacy ID (NABP/NPI) No:** \_\_\_\_\_ **Pharmacy Name:** \_\_\_\_\_  
 (Can be found on either your receipt or Prescription)  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Claim 1** Prescription No.: \_\_\_\_\_ Date Filled: \_\_\_\_\_  
 Drug Name: \_\_\_\_\_ Product ID (NDC) No.: \_\_\_\_\_  
 Days Supply: \_\_\_\_\_ Total Charge: \_\_\_\_\_ Prescribers Name or DEA No.: \_\_\_\_\_

**Claim 2** Prescription No.: \_\_\_\_\_ Date Filled: \_\_\_\_\_  
 Drug Name: \_\_\_\_\_ Product ID (NDC) No.: \_\_\_\_\_  
 Days Supply: \_\_\_\_\_ Total Charge: \_\_\_\_\_ Prescribers Name or DEA No.: \_\_\_\_\_

**Claim 3** Prescription No.: \_\_\_\_\_ Date Filled: \_\_\_\_\_  
 Drug Name: \_\_\_\_\_ Product ID (NDC) No.: \_\_\_\_\_  
 Days Supply: \_\_\_\_\_ Total Charge: \_\_\_\_\_ Prescribers Name or DEA No.: \_\_\_\_\_

**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 90<sup>th</sup> St. Ste 100, Scottsdale, AZ 85258**  
 (Rev 10/07)