



# Prescription Drug Reimbursement Form

This form should be used to obtain reimbursement for prescription(s) purchased without your prescription drug card. For reimbursement consideration, please complete all three sections below:

## 1 CARD HOLDER INFORMATION

Member ID No.: \_\_\_\_\_ Name: \_\_\_\_\_  
(Can be found on your ID card) (First) (Middle Initial) (Last)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Plan Name: \_\_\_\_\_ Group No.: \_\_\_\_\_  
(Your day time number) (Employer, Group or Organization) (Can be found on your ID card)

- 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: \_\_\_\_\_

## PATIENT INFORMATION

## 2

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First) (Middle Initial) (Last) (Month/Day/Year)

Gender: \_\_\_\_\_ Relationship to Card Holder: \_\_\_\_\_  
(Male/Female) (Self/Spouse/Child/Other)

## 3 PRESCRIPTION INFORMATION

Pharmacy ID (NABP) No.: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_  
(Can be found on either your receipt or prescription label)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

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

- Remember...**
- ✓ Most information above can be obtained from the prescription label(s) and/or receipt(s). Have your pharmacy complete **any** missing information.
  - ✓ 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 three sections above, please mail this form and paid pharmacy receipt(s) to:

SXC Health Solutions, Inc. - Claims Processing  
 PO Box 3163 - Lisle, IL 60532-8163