Direct Member Reimbursement Form

This form should be used to obtain reimbursement for a prescription that was purchased without the use of your prescription card.

Insured Member Information:

Member ID: _____ Member Name: _____

Make Check Payable To: ___Cardholder ___Patient (Please Check One)

Payee: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Information:

Patient Name: _____

Date of Birth: _____ Sex: ___ Male ___ Female

Relationship to Insured: __ Self __ Spouse __Child __Other

Prescription Information:

Secondary Claim/COB: ___Yes ___No

Please attach pharmacy receipts, which must reflect the following:

Rx Number	Fill Date
Quantity Dispensed	Day Supply
NDC Number	Amount Paid

If you have any questions regarding reimbursement, please contact Customer Service at 800-519-8374.

Mail to: ATTN: DMRs
PharmaCare
695 George Washington Highway
Lincoln RI 02865
or Fax to: 401-335-7001