Prescription Reimbursement Form

How to use this form

Use this form to request prescription reimbursement for eligible prescriptions claims that you paid for out of pocket or out of network.

To ensure faster processing of your claim, be sure to do the following:

- Complete the form on your computer or print it out and complete it using black or blue ink and print clearly and legibly
- Complete all the applicable fields on the form
- Include a copy of your receipt and pharmacy bag tag if available
- Only use one form per claim

If you have other insurance or Medicare, and it is primary to your plan, please include the explanation of benefits (EOB) from your other insurance or Medicare.

To receive the maximum benefit

Use a participating pharmacy to receive the maximum benefit. Your pharmacist can provide you with the most cost-effective options for your prescription.

For prescriptions that require prior authorization or notification, be sure to call the Member Services number on the back of your ID card.

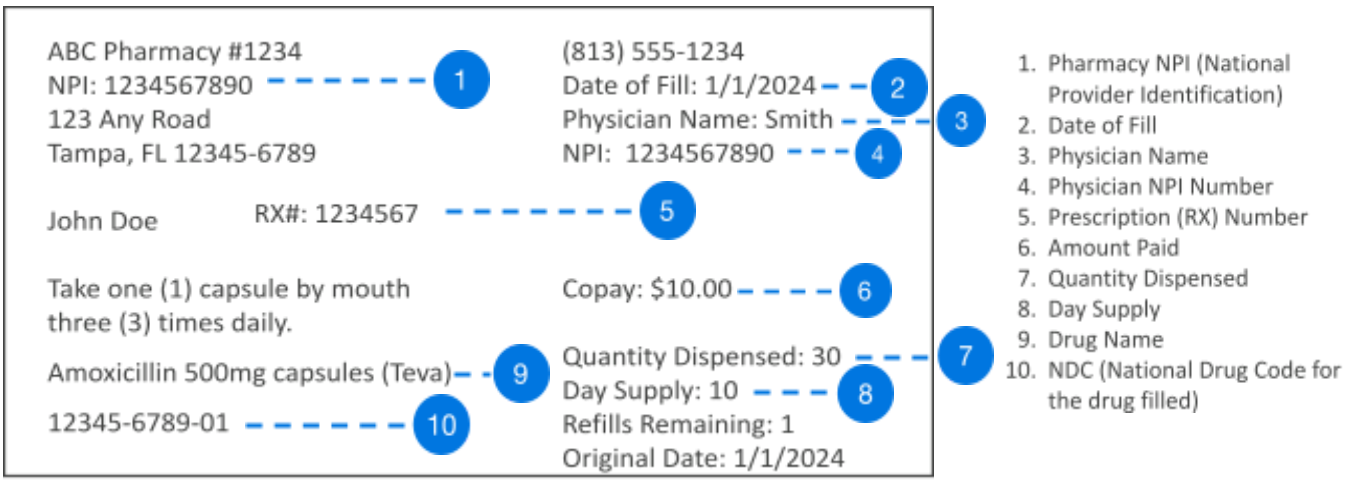
What happens next

Once you have completed the form, mail it with a copy of your receipt to the address below.

Address: ATTN: RxSense DMR Team
99 High Street, Suite 2800
Boston, MA 02110

Your request will be processed, and a response provided via email in approximately 4-6 weeks.

Below is a sample prescription label. Use this as a guide to find the information you need to complete this form. Each pharmacy has its own label format. Please ask your pharmacy to obtain any missing information.



1. Pharmacy NPI (National Provider Identification)
2. Date of Fill
3. Physician Name
4. Physician NPI Number
5. Prescription (RX) Number
6. Amount Paid
7. Quantity Dispensed
8. Day Supply
9. Drug Name
10. NDC (National Drug Code for the drug filled)

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**Required field*

Member Information

Patient's Name (Last Name, First Name, MI)*	Patient's DOB*	Patient's Sex*
Patient's Email*		Patient's Phone*
Insured's Name (Last Name, First Name, MI)*	Patient's Relationship to Insured*	
ID Number (on the front of your card)*	Account/Plan Number (on the front of your card)*	

Prescription Information

Date Filled*	RX Number*	Quantity Dispensed*	Day Supply*
Drug Name*			Drug Strength*
Dosage Type (Optional)	Manufacturer (Optional)		
NDC#*	Pharmacy Name*		
Pharmacy NPI (Optional)	Pharmacy NABP*		Amount Paid (Receipt Required)*
Pharmacy Address*			
Prescriber Name (Last Name, First Name)*		Prescriber NPI (Optional)	
Prescriber Address (City, State, Zip)*			

Acknowledgement

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature*	Date*	Phone*

Return Address

IMPORTANT: *Provide current mailing address. (A copy of the receipt must be included)*

First Name*	Last Name*
Street Address*	City, State, Zip*