MEMBER REIMBURSEMENT FORM (PRESCRIPTION DRUGS)

MEMBER INFORMATION

PLAN NAME: **PHYSICIANS HEALTH CHOICE**			MEMBER ID #		
MEMBER NAME (Last Name, First Name, M.I.)	MEMBER SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH			
		MO	DAY	YEAR	
MAILING ADDRESS OF MEMBER (Number and Street)	CITY	ZIP CODE			

I CERTIFY THAT THE MEMBER FOR WHOM THIS CLAIM IS MADE IS A COVERED PERSON IN THIS BENEFIT PROGRAM AND THAT THESE PRESCRIPTIONS ARE FOR THE SOLE USE OF THE NAMED MEMBER. I ALSO CERTIFY THAT THE CLAIM(S) BEING SUBMITTED FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT AUTOMOBILE OR WORKERS COMPENSATION PROGRAM.

MEMBER/Authorized Representative Signature: **X**____

Telephone Number: (____)____

PRESCRIPTION INFORMATION

CLAIM NO. 1	FOR OFFICE USE ONLY	RX NUMBER	DATE FILLED	NEW RX ☐	REFILL RX ☐	DRUG NAME & STRENGTH
NATIONAL DRUG CODE (NDC #) _ _ _ _ _ / _ _ _ _ / _ _			METRIC QTY. DISPENSED	DAYS SUPPLY		AMOUNT PAID $

CLAIM NO. 2	FOR OFFICE USE ONLY	RX NUMBER	DATE FILLED	NEW RX ☐	REFILL RX ☐	DRUG NAME & STRENGTH
NATIONAL DRUG CODE (NDC #) _ _ _ _ _ / _ _ _ _ / _ _			METRIC QTY. DISPENSED	DAYS SUPPLY		AMOUNT PAID $

PHARMACY INFORMATION

NAME, ADDRESS & TELEPHONE NUMBER OF PHARMACY	N.A.B.P. PHARMACY IDENTIFICATION NUMBER

I CERTIFY THAT THE CHARGE SHOWN IS FOR THE DRUG(S) DISPENSED TO THIS RECIPIENT.
(Signature & License # of Pharmacist requested)

X____

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

INSTRUCTIONS

A. WHEN TO USE THIS FORM

This claim form is to be used only when it has been necessary to purchase prescriptions because your participating pharmacy did not honor your identification card or was unable to directly submit your claim. It should also be used when it was necessary to have your prescriptions files at a non-participating pharmacy.

Submit this form to the address below as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to keep the form until completely filled

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under Member **Information.** Transfer the Member ID # and Plan Name from your identification card.

2. Have your pharmacist complete the **PRESCRIPTION INFORMATION** section for each prescription filled and the **PHARMACY INFORMATION** section. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or your receipt.

   IMPORTANT: The drug quantity, drug name and strength **or** eleven digit National Drug Code (NDC) is required and **must** appear on your submitted claim(s) or receipt(s).

3. The original **paid** pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory proof of purchase.

4. **FOR COMPOUNDED PRESCRIPTIONS ONLY:** If your pharmacist tells you this is a compounded prescription ask your pharmacist for assistance. The NDC number appearing on the claim should be that of the most expensive prescription ingredient. Should you have more than one compounded prescription, please use additional claim forms.

5. Claim forms submitted without the required information will cause payment delays or may be returned.

C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to:

   Envision Rx Options, Inc.
   2181 East Aurora Road, Suite 201
   Twinsburg, Ohio 44087

2. Please allow up to eight weeks for processing and payment of your claims.

3. You may call 1-866-417-3064 for questions or problems concerning your submitted claims.

CLAIMS WITH MISSING OR ILLEGIBLE INFORMATION WILL BE RETURNED!