Alluma™

Prescription reimbursement request form

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Subscriber Information

RxGroup *(see ID card)*

Member ID *(see ID card)*

2 Patient Name/ DOB

Last Name

First Name

MI

Mailing street address

Apt. #

City

State

Zip

Prescription is for ☐ Self ☐ Spouse ☐ Dependent

Gender ◉ M ○ Female

Date of birth (mm/dd/yyyy) ____/____/____

3 Physician and pharmacy information

Prescribing physician name

Dispensing pharmacy name

Prescribing physician phone number with area code

Dispensing pharmacy phone number with area code

4 Reason for request

○ New to the plan - Did not have ID card

○ Emergency *(please explain)* _____

_____

○ Other *(please explain)* _____

_____

5 Acknowledgment

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ **Date:** _____

Instructions for submitting form

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.

2. Read the Acknowledgment (section 4) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.

3. Send completed form with pharmacy receipt(s) to: **Alluma, 320 S. Polk Street, Suite 200, Amarillo, Texas 79101** Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement.Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A - Pharmacy receipts for reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

- ○ Date prescription filled
- ○ Name and address of pharmacy
- ○ Prescribing physician name or ID number
- ○ National Drug Code (NDC) number
- ○ Name of drug and strength
- ○ Prescription number (Rx number)
- ○ Quantity

Section B - Pharmacy information *(for compound prescriptions ONLY)*

(Pharmacist must complete and sign)

- List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient used in the compound prescription.
- For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.

***** Individual quantities must equal the total quantity.

† Individual ingredients costs plus compounding fees must be equal to the total ingredient costs.

X _____
Signature of Pharmacist

Rx#	Date Filled	Days Supply

VALID 11 Digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee		
Total		

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.