

Date:

## Prescription reimbursement request form

Signature:

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	1			
	RxGroup (see ID card)		Member ID (see ID card)		
2	Patient Name/ DOB				
	Last Name		First N	Name	MI
	Mailing street address				Apt. #
	City	State	Zip	Prescription is for OSO Spouse ODependo Date of birth (mm/dd/yyyy)	
3	Physician and pharma	cy information			
	Prescribing physician name			Dispensing pharmacy nam	ne
	Prescribing physician phone number with area code			Dispensing pharmacy pho number with area code	ne
4	Reason for request				
(	New to the plan - Did not have ID ca	ard			
(	Emergency (please explain)				
(	Other (please explain)				
5	Acknowledgment				
	patient, if not myself) am eligible	for prescription drug	benefits. I als	so certify that the medication	y the patient above, and that I (or the ns received were not for treatment of these benefits to a pharmacy or any

## 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.

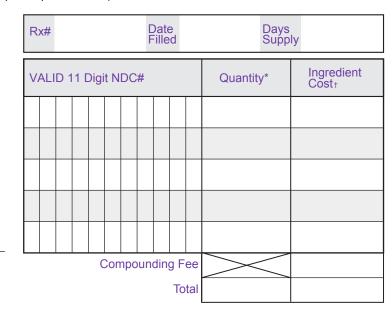
Section A - Pharmacy receipts for r	eimbursement				
Ise the following checklist to ensure your receipts have all information required for your reimbursement request:					
Date prescription filled     Name and address of pharmacy	O National Drug Code (NDC) number O Name of drug and strength	O Prescription number (Rx number) O Quantity			
O Prescribing physician name or ID number					

## 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.

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	Signature of Pharmacist



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.