

SCRIPT CARE, LTD.

6380 Folsom Drive
Beaumont, TX 77706

Direct Reimbursement Claim Form

IMPORTANT INSTRUCTIONS:

When should you use this form:

- Between the effective date of the Script Care program and receipt of your ID card.
- If you are unable to use a participating pharmacy.

Your claim cannot be processed unless this form is complete.

- A separate claim form must be completed for each patient.
- Complete all information requested under Part A.
- Tape prescription receipt(s) to form under Part B - DO NOT STAPLE.

Use back of form for additional receipt(s).

- Review, sign, and mail completed form with receipt(s) to the address at the top of this form.

Claims returned for missing information:

Please provide highlighted information and resubmit.

Claim form required	Pharmacy receipt(s)	Patient ID number
Date Dispensed	Prescription Number	Amount Paid
National Drug Code (NDC)	Quantity	Days Supply

Patient not in system, contact your health plan or employer.

Other _____

Part A: To be completed by you.

Group Number

Cardmember ID Number

Member Name & Address, Street, City, ST Zip

Patient Name

Patient DOB

Patient Gender: M F (circle one)

Patient is: Self Spouse Child (circle one)

I certify that the medication(s) described hereon was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to any interested party for use in connection with the benefit plan programs. The undersigned further authorizes use of such person's social security number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

Member

Signature: _____ Date: _____

Part B: Prescription receipts.

Rx #1

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #2

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #3

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #4

Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy