

# Prescription Reimbursement Request Form

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## Who Should Use This Form

Use this form if you paid out-of-pocket for a covered prescription and would like to request reimbursement under your pharmacy benefit.

## Filing Deadline

Submit your form within the timeframe outlined in your specific plan benefits (typically 120 days to one year from the date of purchase).

## Important

Claims paid using a discount card, manufacturer coupon, or pharmacy discount program are not eligible for reimbursement under your pharmacy benefit.

## Before You Submit

- Complete all applicable fields
- Submit one form for each claim
- Attach a copy of your pharmacy receipt
- Include the Explanation of Benefits (EOB) if another insurance plan paid first
- Include a brief note if the prescription was filled during a disaster or emergency
- Include a Universal Claim Form (UCF) for compound prescriptions, if available. The pharmacy can provide this form upon request.

## How to Submit

Email your completed form and receipt to:  
[Help@AffirmedRx.com](mailto:Help@AffirmedRx.com).

## What Happens Next

Most claims are processed within **2-4 weeks** of receipt.  
To check claim status, contact Member Services at the number on your ID card

### SECTION 1: REASON FOR REIMBURSEMENT

- Pharmacy could not process my insurance
- Emergency or urgent medication need
- No in-network pharmacy available
- Coverage or eligibility issue (e.g., coverage not active, authorization pending)
- Coordination of Benefits (COB) (another insurance plan paid first – EOB required)
- This is a compound prescription
- Other (please explain) \_\_\_\_\_

### SECTION 2: PRIMARY CARDHOLDER INFORMATION

Primary Cardholder Name (Last Name, First Name, MI)	Primary Cardholder ID Number (on front of card)
Group Number	Employer/ Plan Name (if applicable)

### SECTION 3: PATIENT INFORMATION (Complete only if different from the member)

Patient Name (Last Name, First Name, MI)	Patient's DOB (MM/DD/YYYY)
Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Patient's Person Code (on front of card)

### SECTION 4: PRESCRIPTION INFORMATION

#### Prescription Detail

Date Filled (MM/DD/YYYY)	Rx Number
Medication Name	Strength
Quantity	Days' Supply
Out-of-Pocket Amount Paid by Member	NDC

#### Pharmacy Detail

Pharmacy Name	Pharmacy Phone	
Pharmacy Street Address	Pharmacy City	Pharmacy State & Zip
NABP or NPI (if available on receipt)		

**Prescriber Detail**

Prescriber Name	Prescriber NPI (if available)
City	State

**SECTION 5: CLAIM RECEIPT REQUIREMENTS**

Submit a copy of the pharmacy receipt with this form. The receipt must include:

- Pharmacy name
- Date Filled
- Prescription (Rx) number
- Medication name and strength
- Quantity and day supply
- Amount paid
- NDC number (11-digital code, if available)
- Prescriber name (if available)
- DAW – Dispense as Written indicator (if available)

If another insurance plan paid first, include a copy of the Explanation of Benefits (EOB)

**SECTION 6: COMPOUND PRESCRIPTION (If Applicable)**

**Complete only if the prescription submitted is a compound medication.**

Provide ingredient-level NDC (11-digit), quantity, cost per ingredient and total compound charge. Attach supporting pharmacy documentation, including ingredient detail and pricing.

Valid 11 Digit Ingredient NDC	Metric Quantity (grams/mL/tablets)	Ingredient Cost
Total Compound Amount Paid		

Attach a separate sheet if additional ingredients are required.  
 Include a Universal Claim Form (UCF), if available. The pharmacy can provide this form upon request.

**SECTION 7: CERTIFICATION & SIGNATURE**

I certify that the information provided on this form is true and complete to the best of my knowledge. I confirm that the amounts listed represent my out-of-pocket expense for the prescription identified above. I authorize the release of information necessary to process this request.

I understand that reimbursement is subject to the terms and conditions of my pharmacy plan.

Member Signature: \_\_\_\_\_  
 Date (MM/DD/YYYY): \_\_\_\_\_  
 Printed Name: \_\_\_\_\_

**Reimbursement Mailing Address (if different from address on file)**

Reimbursement will be mailed to the address on file under the member's eligibility record unless a different address is provided below.

Street Address: \_\_\_\_\_  
 City | State | Zip: \_\_\_\_\_