AffirmedRx
PUBLIC BENEFIT CORPORATION

Prescription Drug Claim Reimbursement Form

How to Use this Form

Use this form to request prescription reimbursement for eligible prescriptions claims that you paid for out of pocket or out of network.

You must submit within one year of purchase.

A discount card is not insurance. Your plan may consider that claim fully paid and additional reimbursement might not be provided.

To ensure faster processing of your claim, be sure to do the following:

- Complete the form on your computer or print it out and complete it using black or blue ink and print clearly and legibly.
- Complete all the applicable fields on the form.
- You may only use one form per claim.

If you have other insurance or Medicare, and it is primary to your plan, please include the explanation of benefits (EOB) from your other insurance or Medicare.

When to Submit a Request for Reimbursement

- You didn't use your prescription drug ID card
- You used an out-of-network pharmacy for one of the following reasons:
  - You needed drugs while traveling outside the plan's service area but couldn't go to a network pharmacy.
  - You were unable to get drugs in a timely manner from either a network pharmacy located within a reasonable distance or a network mail service pharmacy.
  - You received the drugs from an out-of-network pharmacy located within a care facility (emergency department, provider based clinic, outpatient surgery or other outpatient facility).
  - You were evacuated or displaced from your home due to a state or federally declared disaster or health emergency.

- You were unable to fill a compound prescription at a network pharmacy.
- Your primary coverage is with another insurance carrier and you are requesting reimbursement for their cost share.
- You were waiting for a drug approval.
- You retroactively enrolled in the plan.
- The pharmacy billed the wrong plan.
- You received a covered vaccine and/or vaccine administration in an outpatient setting.

To Receive the Maximum Benefit

Use a participating pharmacy to receive the maximum benefit. Your pharmacist can provide you with the most cost-effective options for your prescription.

For prescriptions that require prior authorization, be sure to call the Member Services number on the back of your ID card.

What Happens Next

Once you have completed the form, email it along with a copy of your receipt, to the address to Help@AffirmedRx.com. Your request will be processed and a response provided in approximately 2-4 weeks from receipt.

- To check the status of your claim, please call the Customer Service number on the back of your ID card.

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Reason for Reimbursement

- ☐ Did not use my Prescription Drug ID Card
- ☐ Went to a non-participating provider
- ☐ Have primary coverage with another carrier (Explanation of Benefits (EOB) is required to be submitted with this form)
- ☐ Was waiting for drug approval
- ☐ Purchased medication outside the country
- ☐ Compound Prescription

Member Information

Patient's Name (Last Name, First Name, MI)	Patient's DOB	Patient's Sex
Patient's Email		Patient's Phone
Member's Name (Last Name, First Name, MI)	Patient's Relationship to Insured	
Member ID Number (on the front of your card)	Patient's Person Code (on the front of your card)	
Group Number	Employee Name	

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Prescription Information

Date Filled	Rx Number	Quantity	Day's Supply
Drug Name			Drug Strength
Dosage Type (Optional)	Manufacturer (Optional)		
Pharmacy Name	Pharmacy NABP (Optional)		Amount Paid (Receipt Required)
Pharmacy Address		Pharmacy Phone Number	
Prescriber Name (Last Name, First Name)		Prescriber NPI (Optional)	
Prescriber Address (City, State, Zip)			

Compound Prescriptions Only

Rx Number	Prescription Fill Date	Day Supply

Valid 11-digit Ingredient NDC	Quantity	Ingredient Cost
Total Quantity		
Total Charge		

- List the valid 11-digit NDC number for each ingredient used for the compound prescription.
- For each NDC number, indicate the metric quantity in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Include the total charge paid by the patient. (dollar amount)
- Receipts must be included with the completed claim form

Claim Receipts

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID name
- NDC number (drug number)
- Name of drug and strength
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

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Acknowledgment

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature	Date	Phone

Return Address

IMPORTANT: Provide current mailing address for reimbursement.
(A copy of the receipt must be included)

Name	
Street Address	
City, State, Zip	