Medalist Rx 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 Member Information

RxGroup *(see ID card)* | Member ID *(see ID card)*

Last Name | First Name | MI

Mailing Street Address | Apt. #

City | State | ZIP

State

Prescription is for ○ Self ○ Spouse ○ Dependent

Gender ○ M ○ F

Date of Birth *(mm/dd/yyyy)* 00 / 00 / 1900

2 Physician and Pharmacy Information

Prescribing Physician Name | Dispensing Pharmacy Name

Prescribing Physician Phone Number with Area Code | Dispensing Pharmacy Phone Number with Area Code

3 Reason For Request

Select appropriate options for your request:

- ○ I did not use my Prescription Drug ID card
- ○ I used a non-participating pharmacy *(please explain)* _____
- ○ I filled a compound prescription *(your pharmacist must complete section B on the back of this form)*
- ○ I purchased medication outside of the United States
  Country _____ Currency used _____
- ○ My primary coverage is with another insurance carrier *(coordination of benefits claim; see section C on back for details)*
  - ○ I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
  - ○ I am submitting a copay receipt
- ○ I was waiting for a drug approval
- ○ I was retroactively enrolled with the plan
- ○ My pharmacy billed the wrong plan
- ○ Other *(please explain)* _____

4 Acknowledgement

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), unless approved OTC product then register receipt may be used. 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. Send completed form with pharmacy receipt(s) to: **MedalistRx Claims Department,** **2431 E. 61st Street, Ste 450 Tulsa, OK 74105**
Email info@medalistrx.com

3. **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 ingredient costs plus compounding fees must be equal to the total ingredient costs.

Rx#		Date Filled		Days Supply	

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

X _____
Signature of Pharmacist

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

***Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

***California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.