DIRECT MEMBER REIMBURSEMENT FORM

Please attach a detailed receipt from the pharmacy, including all of the following information. If this information is not on the receipt, please have the pharmacist complete and sign this form and attach proof of payment. **Without the required information HealthSmart Rx will not be able to process your claim.**

PRESCRIPTION FILLED FOR (Patient Name):	DATE OF BIRTH (Patient DOB):
PLAN PARTICIPANT IDENTIFICATION NUMBER (Printed on prescription card):	
MAILING ADDRESS:	
PLAN NAME (Employer or Group Name):	

RX #	Pharmacy NABP/NPI #	Fill Date	Drug Name *(including strength)*	NDC Number	Physician DEA/NPI #	Quantity	Days Supply	Amount Paid

PHARMACIST SIGNATURE: _____ **PHARMACY PHONE NUMBER:** _____

**PHARMACIST SIGNATURE IS REQUIRED WHEN A DETAILED RECEIPT IS NOT PROVIDED.*

All reimbursements are subject to plan terms and conditions and may be reduced from the submitted amounts based on plan cost and copayments. Any reimbursement due will be refunded to the policy holder.

Please check one of the following reimbursement request reasons:

- ☐ Member did not have the HealthSmart Rx prescription drug card with them.
- ☐ Member did not receive the HealthSmart Rx prescription drug card before the time of purchase.
- ☐ Vacation supply
- ☐ Claim was rejected at the pharmacy.
- ☐ Claim consideration for Coordination of Benefits (secondary coverage).
- ☐ Out of network purchase.
- ☐ Other; Please attach a detailed explanation to be considered for reimbursement.

Mail to:
HealthSmart Rx, Inc.
3320 West Market St
Fairlawn, OH 44333