DIRECT MEMBER REIMBURSEMENT FORM

Please attach a detailed receipt from the pharmacy, including all of the information in the form below. 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, HealthSmartRx Solutions 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: ____________

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.

☐ Member did not have the HealthSmartRx prescription drug card with them

☐ Member did not receive the HealthSmartRx 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 attached a detailed explanation to be considered for reimbursement

Mail to:

HealthSmartRx Solutions
3320 West Market Street
Fairlawn, OH 44333