MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription labels and mail to:

Catamaran
P.O. Box 968022
Schaumburg, IL 60196-8022

Cardholder Information

Cardholder's ID Number	Group/Employer/Union Name and Number:
Cardholder's Name: (Last, First, Middle)	Cardholder's Birthdate: (MM/DD/YYYY)
Cardholder's Address: (Street, City, State, Zip)	Cardholder's Phone Number:

Patient Information

Prescription(s) were for:

Patient Name: (First, Middle, Last)	Gender: ☐ Male ☐ Female	Employee ☐ Spouse ☐ Dependent ☐	Patient Birthdate: (MM/DD/YYYY)

Reason for Request

☐ Coordination of benefits with primary pharmacy or medical plan.

☐ Compound claim

☐ Out of area/ urgent/emergency request

☐ Eligibility issue at the pharmacy

☐ Other, please describe:

Pharmacy Information

Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, Zip)	
Pharmacy Telephone Number: ( )	Pharmacist Signature: Date:

Prescription Information

Please include the **prescription labels** *with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your* **pharmacist** *for assistance in completing the information below. Completing this entire form will result in timely processing of your claim.*
For questions concerning this claim please call the toll free number listed on your pharmacy ID card.

❶ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)
Medication Name, Strength, Dosage Form:			Physician Name:	NPI/DEA #	Rx Price Paid:

❷ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)
Medication Name, Strength, Dosage Form:			Physician Name:	NPI/DEA #:	Rx Price Paid:

❸ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)
Medication Name, Strength, Dosage Form:			Physician Name:	NPI/DEA #:	Rx Price Paid:

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature: Date: