

PRESCRIPTION DRUG CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

Date received:

Name of person requesting reimbursement:

Phone number:

Name of member:

Complainant relationship with member:

ID number:

Reason for reimbursement:

Date of purchase:

Amount paid:

Note: Reimbursement amount will be equal to amount paid minus any applicable copays

Pharmacy name:

Pharmacy phone number:

Pharmacy address:

Provider Name:

Provider phone number:

I certify the above information is correct, and the prescriptions listed above are for me or for eligible members of my family who have received the medication described on this form. I authorize release of all information contained on this claim.

Member signature

Date

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

MAIL TO

Navitus Health Solutions, LLC

PO Box 999

Appleton, WI 54912-0999 OR

Fax this form along with receipt(s) to:

920-735-5315 / Toll Free 855-668-8550

Please include all itemized receipts or your request may be delayed.

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.

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