Prescription Drug Claim Form

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM

Use this claim form to request reimbursement for prescription drugs purchased:

⇒ Between the effective date of your prescription coverage and the receipt of your card.

⇒ When prescription drugs are purchased at a non-participating pharmacy.
(Note: Only if allowed by your plan)

When filling out claim form (reverse side):

⇒ Complete a separate form for each family member for whom prescription drugs were purchased.

⇒ Complete the top portion of the form in full. Incomplete forms will be returned to you.

⇒ Attach a copy of your prescription receipt to the Prescription Drug Claim Form.

⇒ Include these numbers from your prescription card:
- Cardholder's (insured) Identification (ID) Number.
- 4-digit Carrier/Plan/Group Code.
- Person Code: Three-digit number assigned to individual family member.

When form is complete:
(Please do not send forms until you receive your prescription card).

⇒ Fold with address on outside and affix postage.

⇒ **ALL INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.**

If you have any questions, please call RESTAT's Customer Service at 1-800-248-1062.

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

FROM:

____

____

____

AFFIX POSTAGE

RESTAT
PATIENT REIMBURSEMENT
P.O. BOX 758
WEST BEND, WISCONSIN 53095-0758

Please read REVERSE SIDE before completing this form. PLEASE PRINT

Cardholder Name:____
First **Middle** **Last**

Cardholder ID Number: ________________________ **4-digit Carrier / Plan / Group Code:** ___________

Cardholder Address: ____
Street

____
City **State** **Zip**

Employer Name:__________________________ **Insurance Company**:____________________________

Patient Name:____
First **Middle** **Last**

Person Code____________**Patient's Date of Birth**____/____/____ **Patient Sex: M F (Circle One)**

If your medication is covered under ANY OTHER Insurance Plan, provide the name of the Employer and Insurance Company: ____

Note: If the Primary Insurance Company does not pay a pharmacy benefit, an Explanation of Benefits from the Primary Insurance Company OR a print-out from the pharmacy explaining the reason for non-payment should be submitted with this claim form.

I certify that the above information is correct and that the person is eligible for benefits. I have received the medication described below and authorize release of all information contained on this voucher to RESTAT and the underwriter.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

CARDHOLDER SIGNATURE: ____

TO RECEIVE REIMBURSEMENT:

Attach copies of prescription receipts showing the following information:

- Pharmacy Name and Address
- Prescription Number
- Drug Name
- Drug Cost
- Patient Name
- Fill Date
- Quantity & Days supply

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.