MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription receipts and mail to:
Simply Healthcare Plans
9250 W. Flagler St., Suite 600
Miami, FL 33174-3460

Cardholder Information	
Cardholder's ID number:	Group number:
Cardholder's name: (Last, First, Middle)	Cardholder's birthday: (MM/DD/YYYY)
Cardholder's address: (Street, City, State, ZIP code)	
Gender: □ Male □ Female	Cardholder's phone number:

Reason for Request
Prescription(s) were for:
□ 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 code)	
Pharmacy telephone number:	Pharmacy signature: Date:

Prescription Information

Please include the **prescription labels** *with this form (**receipts are 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.

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:

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:
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:

*Members have up to 36 months from the date of service to request a reimbursement.
*This form is not required; however, all of the information mentioned above will be needed to process request.