Prescription Reimbursement Claim Form

Fill out electronically, or print using blue or black ink. **One form per member.**
If you have questions or need additional forms, visit ServeYouRx.com.

You must provide all information requested for this claim to be considered for reimbursement.
Incomplete prescription claim forms will be returned unprocessed.

- The Group Number and ID Number can be found on your Serve You Rx ID Card or listed on your Medical ID Card.
- If necessary, contact your pharmacist to assist you in completing this claim form.
- Complete a separate form for each family member for whom prescription drugs were purchased.
- If submitting more than two claims, please use another claim form.
- Claims must be submitted within 1 year of date of purchase or as required by your plan.

ACME CORPORATION

EMPLOYEE: JOHN SAMPLE
Member ID: 12345678901

DEPENDENTS
JANE **12345678902**
MARY **12345678903**

RxGRP: 1234
RxBIN: 001553
RxPCN: SERVU

ID NUMBER
GROUP NUMBER

ServeYou Rx
ServeYouRx.com
For prescription claims/inquiries call 800-759-3203.

Send completed claim form and prescription receipts to:

Mail: Serve You Rx
Benefit Administration
10201 West Innovation Drive, Suite 600
Milwaukee, WI 53226

Email: BenefitAdmin@ServeYouRx.com

Customer Service

If you have questions, please call Serve You Rx Customer Service at **800-759-3203.**
Monday – Friday: 7:30 a.m. – 9 p.m. CST | Saturday: 8 a.m. – 6 p.m. CST | Sunday: 9 a.m. – 3 p.m. CST

CARDHOLDER/MEMBER INFORMATION

Employer/Health Plan Name: ______________________________

Member ID #: ______________ Group #: ______________

Cardholder Last Name: ______________ First Name: ______________ MI: _____

Date of Birth: __________ Gender: ☐ Male ☐ Female

Permanent Address: ______________ City: ______________ State: _______ ZIP: __________

I certify that all information on this claim form is accurate. I also certify that the patient for whom this claim is made is a covered person in this prescription drug program and that the prescription is for the sole use of the named patient. I understand that Serve You Rx's use or disclosure of individually identifiable health information, whether furnished by me or obtained from another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability Accountability Act of 1996).

Signature: ______________________ Today's Date (month/day/year): __________

Do you have other insurance for prescription medications? ☐ Yes (list name) ______________ ☐ No

Coordination of Benefits (COB) claims are processed only if allowed by your benefit plan. If filing COB claims, please include an Explanation of Benefits (EOB) from the primary insurance carrier indicating the portion of benefits paid.

PATIENT INFORMATION

Patient Last Name: ______________ First Name: ______________ MI: _____

Date of Birth: __________ Gender: ☐ Male ☐ Female

Patient's Relationship to Cardholder/Member: ☐ Self ☐ Spouse ☐ Dependent

PRESCRIPTION REIMBURSEMENT CLAIM FORM

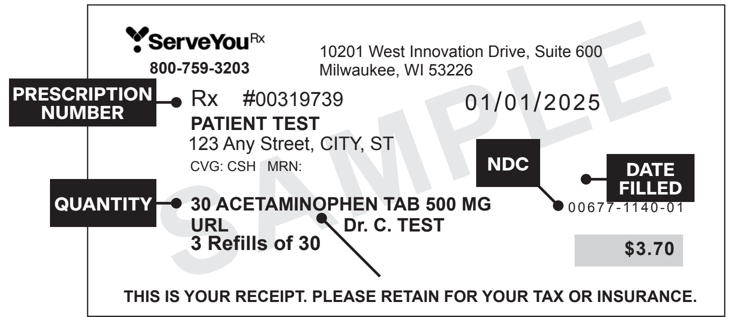
Patient Last Name: ________________________ First Name: ________________________ MI: _____ ☐ Male ☐ Female

PRESCRIPTION INFORMATION.

Use a separate piece of paper if you have more than 2 reciepts.

All receipts must contain the following information:

- ☒ Prescription Number
- ☒ Quantiy
- ☒ Date Filled
- ☒ Days Supply*
- ☒ Name of Medication
- ☒ Amount Paid
- ☒ NDC (National Drug Code)*



Sample Reciept

Attach prescription receipt #1 here

DO NOT STAPLE

Please fill the **NDC** and **Days Supply** if it's not on your receipt.

NDC#: ________________________ Days Supply: ________

Attach prescription receipt #2 here

DO NOT STAPLE

Please fill the **NDC** and **Days Supply** if it's not on your receipt.

NDC#: ________________________ Days Supply: ________

COMPOUND PRESCRIPTION

Compound prescriptions require your pharmacist to complete the following information:

List all ingredients and quantity dispensed for this prescription.

INGREDIENT NAME	STRENGTH	QTY

Attach compound prescription receipt here

DO NOT STAPLE

Please fill the **NDC** and **Days Supply** if it's not on your receipt.

NDC#: ________________________ Days Supply: ________

Active Ingredient(s): ____

Pharmacist's Signature: ________________________ Today's Date (month/day/year): ________