

Prescription Reimbursement Claim Form

SECTION I – CARDHOLDER/MEMBER INFORMATION

EMPLOYER/HEALTH PLAN NAME

GROUP NUMBER

ID NUMBER

CARDHOLDER/MEMBER NAME (FIRST, LAST)

STREET ADDRESS

CITY ST ZIP CODE

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).

CARDHOLDER/MEMBER SIGNATURE

Do you have other insurance for prescription medications?

Yes No

If yes, who? _____

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.

SECTION II – PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)

DATE OF BIRTH (MM/DD/YY)

Male Female

Patient's Relationship to Cardholder/Member:

Self Spouse Dependent

SECTION III – PRESCRIPTION INFORMATION

Receipts must contain the following information:

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

Please refer to Section V for a sample receipt.

Attach Prescription Receipt Here
DO NOT STAPLE

If the information below is not on the receipt, please fill this in. Ask your pharmacist for assistance if needed.

NDC#: _____

Days Supply: _____

Attach Prescription Receipt Here
DO NOT STAPLE

If the information below is not on the receipt, please fill this in. Ask your pharmacist for assistance if needed.

NDC#: _____

Days Supply: _____

Use a separate sheet of paper if you have more receipts.

SECTION IV – COMPOUNDS

Compound prescriptions require your pharmacist to complete the following information:

List all ingredients and quantity dispensed for this prescription.

INGREDIENT NAME	STRENGTH	QTY

ACTIVE INGREDIENT

PHARMACIST SIGNATURE

DATE

Attach Prescription Receipt Here
DO NOT STAPLE

If the information below is not on the receipt, please fill this in. Ask your pharmacist for assistance if needed.

NDC#: _____

Days Supply: _____

SECTION V – SAMPLE RECEIPT

SERVE YOU 10201 West Innovation Drive, Suite 600
1-800-759-3203 Milwaukee, WI 53226

PRESCRIPTION NUMBER ● Rx #00319739	10/01/2022 ● DATE FILLED
PATIENT TEST	
123 Any Street, CITY, ST	
CVG: CSH MRN:	
QUANTITY ● 30 ACETAMINOPHEN TAB 500 MG	● 00677-1140-01 NDC
URL ● Dr. C. TEST	
3 Refills of 30 ● NAME OF MEDICATION	
\$3.70	

THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

SECTION VI – INSTRUCTIONS

You must provide all information requested for this claim to be considered for reimbursement.

The Group Number and ID Number can be found on your Serve You Rx ID Card or listed on your Medical ID Card.

ACME CORPORATION

EMPLOYEE: JOHN SAMPLE Member ID: 12345678901 RxGRP: 1234 RxBIN: 001553 RxPCN: SERVU	DEPENDENTS JANE 12345678902 MARY 12345678903 <div style="border: 1px solid black; padding: 2px; display: inline-block;">ID NUMBER</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">GROUP NUMBER</div>
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SERVE YOU

ServeYouRx.com

For prescription claims/inquiries call:
(800) 759-3203

Incomplete claim forms will be returned unprocessed.

- 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.
- 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

IF YOU HAVE ANY QUESTIONS, PLEASE CALL:

Serve You Rx Customer Service at
800-759-3203

HOURS OF OPERATION:

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

If additional claim forms are needed, please make a copy of this form or download from our website:
serveyourx.com

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ServeYouRx.com

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