

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	<u>DEPENDENTS</u>	
Member ID: 12345678901	JANE	12345678902
	MARY	12345678903
RxGRP: 1234	ID NUMBER	
RxBIN: 001553		
RxPCN: SERVU	GROUP NUMBER	

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

Send completed claim form and prescription receipts to:

Mail: Serve You Rx
Benefit Administration
215 North Water Street, Suite 500
Milwaukee, WI 53202

Email: CustomerService@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 receipts.

All receipts must contain the following information:

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

PRESCRIPTION NUMBER

Rx #00319739
PATIENT TEST
123 Any Street, CITY, ST
CVG: CSH MRN:

10/01/2025

DATE FILLED

QUANTITY

30 ACETAMINOPHEN TAB 500 MG
URL
3 Refills of 30

NAME OF MEDICATION

Dr. C. TEST

NDC

00677-1140-01

\$3.70

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

Sample Receipt

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): _____