Prescription Direct Member Reimbursement Form

Complete and return this form when you have paid full price for a prescribed prescription drug at retail cost and are seeking reimbursement.

Submit this form with the original prescription label receipt(s). Cash register and credit card receipts alone are not acceptable as proof of purchase.

Reimbursement is not guaranteed as claims are still subject to plan benefit rules.

Patient Information (one form per patient)		
Health Plan (Insurance) Name *(please print)*		
Name *(Last Name, First Name, MI)*	Birth Date	I.D. Number
Mailing Address *(Number, Street, City, State & Zip Code)*		
Prescribing Physician's Name		Physician's Telephone Number

Reason For Request

(At least one must be checked)

- ☐ Out of Area emergency medication
- ☐ Non-emergency medication/vacation request
- ☐ No identification card or identification number available
- ☐ Coordination of Benefits (From Primary Insurance – complete section below)
- ☐ Compound medication
- ☐ Member not found in pharmacy system
- ☐ Other:_____

I 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 also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or workers compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder and/or employer.

X_____

Member's/Subscriber's Signature Date

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement may be delayed or denied. Please refer to example on the second page.

- Pharmacy Name
- Drug name, NDC, strength and quantity
- Prescribing physician's name
- Prescription number and date filled
- Member paid expense

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

RightwayRx
PO Box 996
Attn: Paper Claims
Portland, ME 04104

Reimbursement will be issued to the primary member/subscriber.

rightway

Example Prescription Label

Below is an example of a typical prescription label. Use this as a guide to confirm that all the necessary information is available on the pharmacy prescription label before submitting this form for reimbursement.

XYZ Pharmacy Store 1234 555 Street Road New York, NY 1001	Phone: 555-555-1212 Date of Fill: 01/01/2022 Physician Name: Dr. Smith NPI: 1234567890
Jane Doe RX: 123456	
Take one (1) capsule by mouth three (3) times a day.	Copay: $5.00
Amoxicillin 500mg Capsules (TEVA) NDC: 12345-1234-01	Quantity: 30 Day Supply: 10 Refills Remaining: 1 Original Date: 01/01/2022