SCRIPT CARE, LTD. – Attn: Jade Thibodeaux
6380 Folsom Drive
Beaumont, TX 77706

Direct Reimbursement Claim Form

Important Instructions

When should you use this form:

1. Between the effective date of the Script Care program and receipt of your ID card.
2. If you are unable to use a participating pharmacy.

Your claim cannot be processed unless this form is complete.

- A separate claim form must be completed for each patient.
- Complete all information requested under Part A.
- Tape prescription receipt(s) to form under Part B - DO NOT STAPLE.

Use back of form for additional receipt(s).

Review, sign, and mail completed form with receipt(s) to the address at the top of this form

Part A: Completed by member.

Name ____________________

Address ____________________

____

City, State Zip ____________________

Group Number ____________________

Card Member ID Number ____________________

Patient Name ____________________

Patient Date of Birth ____________________

Patient Gender: ☐ Male ☐ Female

Patient is: ☐ Self ☐ Spouse ☐ Child

I certify that the medication(s) described hereon was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to any interested party for use in connection with the benefit plan programs. The undersigned further authorizes use of such person's social security number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

Member Signature ____________________

Date ____________________

Part B: Prescription Receipts.

Rx #1
Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #2
Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #3
Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #4
Tape computer receipt(s) - DO NOT STAPLE

The receipt(s) must contain the following information:

Prescription (Rx) Number
Date prescription filled
Name of drug
NDC Number
Quantity dispensed
Day supply
Amount paid
Name and address of pharmacy

Rx #5 **Tape computer receipt(s) - DO NOT STAPLE** The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy	**Rx #6** **Tape computer receipt(s) - DO NOT STAPLE** The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy
Rx #7 **Tape computer receipt(s) - DO NOT STAPLE** The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy	**Rx #8** **Tape computer receipt(s) - DO NOT STAPLE** The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy

Claims returned for missing information:

Please provide highlighted information and resubmit.

Claim form required
Pharmacy receipt(s)
Patient ID number
Date Dispensed
Prescription Number
Amount Paid
National Drug Code (NDC)
Quantity
Days Supply
Patient not in system, contact your health plan or employer.

Other:____

Explanation of Benefits

Your claims have been processed and no payment was made on the following claims for the reason(s) indicated:

	Rx Date	Rx Number	Rejection Code(s)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

1. The claims have been applied toward your deductible.
2. The claim reimbursement is less than your copayment.
3. The medication was refilled too soon, according to the plan design.
4. The claims submitted are for medications that are not covered under your plan.
5. The patient was not covered at the time the claims were incurred.
6. The claims have already been adjudicated by Script Care.
7. Claims older than _____ days/months are not eligible.
8. Your plan does not cover direct reimbursement claims.
9. Your plan allows only a _____ day supply through a retail pharmacy.
10. The claims submitted exceed maximum dispensing limits.
11. Other____