catamaran™

Member Prescription Claim Reimbursement Form

Use this claim form to seek reimbursement for prescriptions obtained without the use of your pharmacy benefit plan. Reimbursement is based on your plan's maximum benefit. For questions, call the phone number listed on your ID card. ***Only one patient per form.***

Group Name: _____ RxGrp # (from ID card): _____

Member Information

Name: _____ ID# (from ID card): _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Patient Information

☐ I am the member (may leave name and relationship blank)

Name: _____ Relationship to Member: ☐ Spouse (02) ☐ Dependent (03)

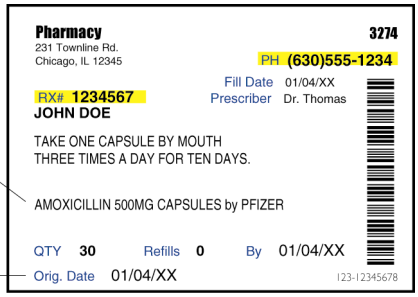
Birth Date (MM/DD/YYYY): _____ Reason for Reimbursement: _____

Pharmacy/Prescription Information

Incomplete information may delay processing or cause the form to be returned. To complete the information below, please refer to your prescription label and cash register receipt. You may also contact the pharmacy where the medication was filled.

The name of the medication prescribed

The amount of pills or liquid medication dispensed



Please use this example only as a guide to locate the required information. Each pharmacy may have their own unique label format.

Drug Name	Total Quantity	Days Supply	Amount Paid $
Pharmacy NCPDP #: *(if unknown, contact the pharmacy)*	NDC #: *(if unknown, contact the pharmacy)**		
NPI #: *(if unknown, contact the pharmacy)*			
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Pharmacy NCPDP #: *(if unknown, contact the pharmacy)*	NDC #: *(if unknown, contact the pharmacy)**		
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Drug Name	Total Quantity	Days Supply	Amount Paid $
Pharmacy NCPDP #: *(if unknown, contact the pharmacy)*	NDC #: *(if unknown, contact the pharmacy)**		
NPI #: *(if unknown, contact the pharmacy)*			

If request is for a compound prescription please provide the NDC number for the most expensive drug

I certify the prescription(s) referred to above have been received and information stated is accurate. I also authorize the release of all information contained herein to Catamaran and its agents. I understand that all prescription receipts must be submitted in order to be processed and considered for reimbursement.

Member Signature: _____ Date: _____

MAIL THIS CLAIM FORM, ALONG WITH BOTH THE PRESCRIPTION AND CASH REGISTER RECEIPT TO:
Catamaran · PO Box 141239 · Irving, TX 75014-1239