

Member Name: \_\_\_\_\_  
*Last*
*First*
*Middle Initial*

Telephone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member's ID # (Located on front of card): \_\_\_\_\_

Note: If approved, your reimbursement will be sent to the address on file for the subscriber. If you need to update your address, please contact Member Services at 850-383-3311.

## Prescription Drug Reimbursement Checklist:

**Request for Reimbursement:**

Please indicate reason for reimbursement request (ex. COBRA, lost card, out of the area, out of the country, etc):

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**Documentation For Reimbursement:**

Please attach the detailed print-out from your pharmacist for *each* prescription. This print-out must include the following information: member's name, date of birth, name of medication(s), dosage, quantity, purchase amount, pharmacy information, prescriber information, date of purchase, and label from the prescription drug purchase. *(Credit card receipts, bank statements, or cashier's receipts do not provide sufficient information.)*

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

*Reimbursement requests can take up to 30 days to process. It may take longer if additional information is needed to process the request.*

**Mail completed form to:**  
 Prime Therapeutics  
 Commercial Claims Department  
 PO Box 21870  
 Lehigh Valley, PA 18002-1870