






Prescription Drug Claim Form

Instructions:

-  **Use this claim form to request reimbursement for prescription drugs purchased:**
- ✓ Between the effective date of your prescription coverage and the receipt of your card.
 - ✓ When prescription drugs are purchased at a non-participating pharmacy.
(Note: Only if allowed by your plan)

-  **When filling out claim form (reverse side):**
- ✓ Complete a separate form for each family member for whom prescription drugs were purchased.
 - ✓ Complete the top portion of the form in full. Incomplete forms will be returned to you.
 - ✓ Attach a copy of your prescription receipt to the Prescription Drug Claim Form.
 - ✓ Include these numbers from your prescription card:
 - Cardholder's (insured) Identification (ID) Number.
 - 4-digit Carrier/Plan/Group Code.
 - Person Code: Three-digit number assigned to individual family member.

-  **When form is complete:**
(Please do not send forms until you receive your prescription card).
- ✓ Fold with address on outside and affix postage.
 - ✓ **ALL INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.**

If you have any questions, please call RESTAT's Customer Service at 1-800-248-1062.

Customer Service Hours of Operation: M-F 7AM-1AM CST; SAT & SUN 8AM-5PM CST

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

FROM:

**AFFIX
POSTAGE**

**RESTAT
PATIENT REIMBURSEMENT
P.O. BOX 758
WEST BEND, WI 53095-0758**



Please read REVERSE SIDE before completing this form. (PLEASE PRINT)

Cardholder Name: _____ / _____ / _____
First Middle Last

Cardholder ID Number: _____ 4-digit Carrier / Plan / Group Code: _____

Cardholder Address: _____
Street

City State Zip

Employer Name: _____ Insurance Company: _____

Patient Name: _____
First Middle Last

Person Code _____ Patient's Date of Birth ____/____/____ Patient Sex: M F (Circle One)

If your medication is covered under ANY OTHER Insurance Plan, provide the name of the Employer and Insurance Company: _____

Note: If the Primary Insurance Company does not pay a pharmacy benefit, an Explanation of Benefits from the Primary Insurance Company OR a print-out from the pharmacy explaining the reason for non-payment should be submitted with this claim form.

I certify that the above information is correct and that the person is eligible for benefits. I have received the medication described below and authorize release of all information contained on this voucher to RESTAT and the underwriter.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

CARDHOLDER SIGNATURE: _____

To receive reimbursement:

Attach copies of prescription receipts showing the following information:

- Pharmacy Name and Address
- Prescription Number
- Drug Name
- Drug Cost
- Patient Name
- Fill Date
- Quantity & Days supply
- Amount Paid

Your claim cannot be processed unless this form is complete.