



The Essence of Care

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

Partners Rx
P.O. Box 12119
Scottsdale, AZ 85260

Prescription Drug Program Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. Submit this form with the original prescription label receipt(s). Physician generated receipt(s) are acceptable for vaccine and vaccine administration requests only.

Cash register and credit card receipts alone are not acceptable as proof of purchase. Reimbursement is not guaranteed.

Claims will be reviewed and subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (One form per patient)		
Health Plan	Group Name	I.D. Number
Name (Last Name, First Name, MI)	Birth Date	Member Phone #
Mailing Address (Number, Street, City, State & Zip Code)		
Reason For Request (At least one must be checked)		
<input type="checkbox"/> Out of Area urgent/emergent medication <input type="checkbox"/> Non urgent medication/vacation request <input type="checkbox"/> Compound medication <input type="checkbox"/> Non-contracted pharmacy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Coordination of Benefits (Must provide all receipts that apply to this transaction)		
Vaccine		
<input type="checkbox"/> Filled at pharmacy, and administered at physician's office <input type="checkbox"/> Filled and administered at pharmacy <input type="checkbox"/> Filled and administered at physician's office	Check below all that apply to the cost of the claim <input type="checkbox"/> Vaccine and Administration Cost <input type="checkbox"/> Vaccine Cost	
<p>PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me. I have received the medication, and I authorize release of all information contained on this claim to Partners Rx, the company chosen by my health plan to manage my pharmacy benefit, and the health plan. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</p>		
_____ Member's/Subscriber's Signature		_____ Date
<p>Special Instructions: Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied: Pharmacy Name, Prescription Number, Drug Name*, Strength, Quantity* Date Filled*, Prescribing Physician's Name* and Member Paid Expense*. *Physician receipt must have those items listed with an asterisk or reimbursement could be delayed or denied.</p> <p>The claim(s) will be returned if the member/subscriber's signature is not present.</p>		