catamaran

MEMBER REIMBURSEMENT DRUG CLAIM FORM

Complete this form, attach prescription labels and mail to:

Catamaran
P.O. Box 968022
Schaumburg, IL 60196-8022

Cardholder Information

Cardholder's ID Number:	Group/Employer/Union Name and Number:
Cardholder's Name: (Last, First, Middle)	Cardholder's Birthdate: (MM/DD/YYYY)
Cardholder's Address: (Street, City, State, Zip)	Cardholder's Phone Number:

Patient Information

Prescription(s) were for:

Patient Name: (First, Middle, Last)	Gender: ☐ Male ☐ Female	Employee ☐	Spouse ☐	Dependent ☐	Patient Birthdate: (MM/DD/YYYY)

Reason for Request

☐ Coordination of benefits with primary pharmacy or medical plan.
☐ Compound claim
☐ Out of area/ urgent/emergency request
☐ Eligibility issue at the pharmacy
☐ Other, please describe:

Pharmacy Information

Pharmacy Name:	Pharmacy NABP Number:
Pharmacy Address: (Street, City, State, Zip)	
Pharmacy Telephone Number: ( )	Pharmacist Signature: Date:

Prescription Information

Please include the **prescription labels** *with this form (receipts are not acceptable) or a pharmacy printout signed by the pharmacist. You can ask your* **pharmacist** *for assistance in completing the information below. Completing this entire form will result in timely processing of your claim.*
For questions concerning this claim please call the toll free number listed on your pharmacy ID card.

❶ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #	Rx Price Paid:

❷ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #:	Rx Price Paid:

❸ Date Filled:	Rx Number:	Rx: (Check One) ☐ New ☐ Refill	Quantity:	Day's Supply:	National Drug Code: (11 digits)	
Medication Name, Strength, Dosage Form:			Physician Name:		NPI/DEA #:	Rx Price Paid:

I certify that all information provided on this form is correct and that the prescription(s) submitted are for me or for members of my family who are eligible. I certify that the prescription(s) submitted are for the sole use of the named patient. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Signature: Date:

MEMBER REIMBURSEMENT INSTRUCTIONS

Submitting a Manual Claim

Please take a moment to read the following information for an accurate and timely reimbursement.

- Complete and return the member reimbursement claim form when you are requesting reimbursement of covered pharmacy expenses incurred outside of your prescription card plan.
- A separate member reimbursement claim form is required for each patient.
- Allow up to 30 days from the time you mail your member reimbursement claim form until you receive an explanation of benefits from us.
- The cardholder must sign the claim form.
- The claim will be returned if the required information is missing.
- Please keep a copy of the member reimbursement claim form and documents submitted for your records.
- Please submit your claim timely, failure to do so may result in a denial of the claim based on the time filing provision in your plan.

Coordination of Benefits -or- Submitting Your Copays

- If we are your secondary coverage and you are requesting reimbursement of your copays, please confirm that your prescription plan is set up to coordinate benefits before completing the form and submitting the claim.
- If this prescription plan is your primary prescription plan you cannot submit your copays for reimbursement. The copayment is the responsibility of the cardholder and will not be reimbursed.