Member Reimbursement Form

Smi+hRx

This form is intended for use in reimbursement of pharmacy claims only. The filing of this form does not guarantee reimbursement. Please consult your plan documents for additional coverage information. If you have any questions regarding this form, or require additional forms please contact the SmithRx Support Team at (844) 454-5201.

1. Patient Information (Use a separate claim form for each covered member of the family)

Identification Number _____ **Group Number** _____

Last Name _____ **First Name** _____ **M.I.** _____

Street Address _____

City _____ **State** (XX) _____ **ZIP Code** (XXXXX) _____

Date of Birth (MM/DD/YYYY) _____

Relation to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Sex ☐ M ☐ F

Phone Number (XXX) XXX-XXXX _____

Email Address (required for reimbursement) _____

2. Prescriber Information

Prescriber Last Name _____ **Prescriber First Name** _____

Prescriber Phone Number (XXX) XXX-XXXX _____

Prescriber Fax Number (XXX) XXX-XXXX _____

3. Coordination of Benefits

Are any of these medicines being used to treat on-the-job injuries? ☐ No ☐ Yes

Are any of these medicines covered under another group insurance? ☐ No ☐ Yes

If you answered **Yes** to either of these questions, please see **Section 3.A** on the back of this page.

4. Review, Confirm, and Sign

You're almost done! Be sure to check your answers above as well as the details sections on the back before signing. Also check that your receipts cover each point in Submission Requirements on the back of this page. Missing or illegible information may result in a delay or denial of your claim. When you're ready to send, ensure your receipts are attached, read the following notice, sign below, and mail the forms. Your claim will be processed with 45-days of receipt.

Fraud Notice: 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.

I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

When complete, mail this form to:
SmithRx Reimbursement Services
PO Box 994
Lehi, UT 84043

or fax to (866) 642-5620.

Need help filling out this form?
SmithRx Support Team
(844) 454-5201
help@smithrx.com

Signature _____ **Name** _____ **Date** _____

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Release of Information:
The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

Translated:
By sending in this form, you give SmithRx permission to contact whomever we may need to so we can get you your money back.

What Your Pharmacy Receipts Need To Show To Get a Reimbursement

- Participant Name
- Prescription Number
- Drug Name and NDC Number
- Metric Quantity/Days Supply
- Pharmacy Name and Address or NABP Number
- Purchase Date
- Total Charge

Once you've confirmed your **original pharmacy receipts** (not cash register receipts or photocopies, sorry) cover these points, please attach them to this form however you'd like.

3.A Coordination of Benefits (Only required if you selected Yes to either question in Section 3)

Are any of these medicines covered under another group insurance? ☐ No ☐ Yes

Is the other coverage primary? ☐ No ☐ Yes

If yes, what is the insurance name and ID number?

_____ _____

Insurance name **ID number**

Attach Receipts Here