

# Prescription Claim Reimbursement Form



For claim reimbursement, complete and mail this form to US Script, 2425 W. Shaw Ave., Fresno, CA 93711. Forms can also be faxed to (559) 244-3793. **Incomplete forms will delay processing.** US Script's customer service desk can be reached at (800) 413-7721.

**\*\*To be completed by insured. Please PRINT clearly.**

| I. MEMBER INFORMATION   |        | II. PRESCRIPTION PLAN INFORMATION |           |
|---|--------|-----------------------------------|-----------|
| Member Name:  |        | Insured's Member ID #:            |           |
| Address:  |        | Group #:                          |           |
| Birth Date:   | Phone: | Employer:                         |           |
| III. PATIENT INFORMATION  |        |                                   |           |
| Relationship to insured:  |        |                                   |           |
| <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____   |        |                                   |           |
| Is patient covered by any other medical benefit plan, group policy repayment plan, Medicare, or other government plans?   |        |                                   |           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |        |                                   |           |
| If Yes, give the name of the person carrying coverage: _____  |        |                                   |           |
| If Yes, name of the alternate coverage (group name, employer, association, etc): _____  |        |                                   |           |
| Patient illness or injury (if injury, include a description of the accident, including date and place).   |        |                                   |           |
| Did condition result from employment?   |        |                                   |           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |        |                                   |           |
| If Yes, date you last worked prior to treatment for which claim was made: _____/_____/_____   |        |                                   |           |
| IV. PRESCRIPTION INFORMATION  |        |                                   |           |
| <b>This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription. Alternately, include a copy of your pharmacy receipt with this form.</b> |        |                                   |           |
| Pharmacy Name:  |        | Pharmacy Address:                 |           |
| RX Number:  |        | Date Filled: _____/_____/_____    | Quantity: |
| RX Name & Strength:   |        | Days Supply (30, 60, 90):         |           |
| NDC #:  | DAW:   | Price:                            | Comments: |
| Pharmacy Name:  |        | Pharmacy Address:                 |           |
| RX Number:  |        | Date Filled: _____/_____/_____    | Quantity: |
| RX Name & Strength:   |        | Days Supply (30, 60, 90):         |           |
| NDC #:  | DAW:   | Price:                            | Comments: |

**Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to US Script and my plan sponsor.**

Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_