Member Reimbursement Form

SmithRx

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. Use a separate claim form for each covered member of the family.

IDENTIFICATION NUMBER		GROUP NUMBER	
LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MM/DD/YYYY)
PHONE NUMBER (XXX) XXX-XXXX	MAILING ADDRESS		
SEX ☐ M ☐ F ☐ OTHER	RELATION TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	EMAIL ADDRESS (REQUIRED FOR REIMBURSEMENT)	

Prescriber Information

PRESCRIBER FIRST AND LAST NAME	PRESCRIBER NPI (NATIONAL PROVIDER IDENTIFIER)
PRESCRIBER ADDRESS	PRESCRIBER PHONE NUMBER (XXX) XXX-XXXX

Pharmacy Information

PHARMACY NAME	PHARMACY PHONE NUMBER
PHARMACY ADDRESS	

Prescription Information

(Compound Section below must ALSO be filled out for Compounded Medications)

RX #	DRUG NDC (NATIONAL DRUG CODE NUMBER)	DATE DISPENSED (MM/DD/YYYY))		
MEDICATION NAME		QUANTITY DISPENSED	DAY SUPPLY	RX COST
RX #	DRUG NDC (NATIONAL DRUG CODE NUMBER)	DATE DISPENSED (MM/DD/YYYY))		
MEDICATION NAME		QUANTITY DISPENSED	DAY SUPPLY	RX COST
RX #	DRUG NDC (NATIONAL DRUG CODE NUMBER)	DATE DISPENSED (MM/DD/YYYY))		
MEDICATION NAME		QUANTITY DISPENSED	DAY SUPPLY	RX COST

Compounded Medication Information (If Applicable)

COMPOUND DRUG NAME		MEDICATION DOSAGE FORM ☐ CAPSULES ☐ TROCHE/LOZENGES ☐ ORAL LIQUID ☐ TOPICAL ☐ OTHER	
INGREDIENT #1 QUANTITY	INGREDIENT #1 COST	INGREDIENT #1 NDC NUMBER	INGREDIENT #1 DRUG NAME
INGREDIENT #2 QUANTITY	INGREDIENT #2 COST	INGREDIENT #2 NDC NUMBER	INGREDIENT #2 DRUG NAME
INGREDIENT #3 QUANTITY	INGREDIENT #3 COST	INGREDIENT #3 NDC NUMBER	INGREDIENT #3 DRUG NAME
INGREDIENT #4 QUANTITY	INGREDIENT #4 COST	INGREDIENT #4 NDC NUMBER	INGREDIENT #4 DRUG NAME
INGREDIENT #5 QUANTITY	INGREDIENT #5 COST	INGREDIENT #5 NDC NUMBER	INGREDIENT #5 DRUG NAME

FOR ADDITIONAL MEDICATION REIMBURSEMENTS, PLEASE ATTACH ANOTHER FORM AND SUBMIT WITH THE REQUIRED INFORMATION

Coordination of Benefits (If Applicable)

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 question ABOVE, please provide the information to the right:	Is the other coverage primary? ☐ NO ☐ YES	If yes, what is the INSURANCE NAME and ID NUMBER?	

You're almost done! Be sure to check your answers above as well as the details sections below before signing. Also check that your receipts cover each point in Submission Requirements at the bottom 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 within 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.

When complete, mail this form to:
SmithRx Reimbursement Service
P.O. Box 994
Lehi, UT 84043
-OR-
Fax to:
(866) 642-5620

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.

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

SIGNATURE	NAME	DATE MM/DD/YYYY)

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.

Pharmacy Receipt Submission Requirements

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

Once you've confirmed your **original pharmacy receipts** (Med Guide PLUS cash register receipts showing proof of purchase) cover these points, please attach them to this form

Attach Receipts Here