

SCRIPT CARE, LTD. - Attn. Jade Thibodeaux

6380 Folsom Drive
Beaumont, TX 77706

Direct Reimbursement Claim Form

Important Instructions

When should you use this form:

1. Between the effective date of the Script Care program and receipt of your ID card.
2. If you are unable to use a participating pharmacy.

Your claim cannot be processed unless this form is complete.

- A separate claim form must be completed for each patient.
- Complete all information requested under Part A.
- Tape prescription receipt(s) to form under Part B - DO NOT STAPLE.

Use back of form for additional receipt(s).

Review, sign, and mail completed form with receipt(s) to the address at the top of this form

Part A: Completed by member.

Name _____
Address _____

City, State Zip _____

I certify that the medication(s) described hereon was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to any interested party for use in connection with the benefit plan programs. The undersigned further authorizes use of such person's social security number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

Group Number _____
Card Member ID Number _____
Patient Name _____
Patient Date of Birth _____
Patient Gender: Male Female
Patient is: Self Spouse Child

Member Signature _____
Date _____

Part B: Prescription Receipts.

<p style="text-align: center;">Rx #1</p> <p style="text-align: center;">Tape computer receipt(s) - DO NOT STAPLE</p> <p>The receipt(s) must contain the following information:</p> <p>Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy</p>	<p style="text-align: center;">Rx #2</p> <p style="text-align: center;">Tape computer receipt(s) - DO NOT STAPLE</p> <p>The receipt(s) must contain the following information:</p> <p>Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy</p>
<p style="text-align: center;">Rx #3</p> <p style="text-align: center;">Tape computer receipt(s) - DO NOT STAPLE</p> <p>The receipt(s) must contain the following information:</p> <p>Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy</p>	<p style="text-align: center;">Rx #4</p> <p style="text-align: center;">Tape computer receipt(s) - DO NOT STAPLE</p> <p>The receipt(s) must contain the following information:</p> <p>Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy</p>

Rx #5 Tape computer receipt(s) - DO NOT STAPLE	Rx #6 Tape computer receipt(s) - DO NOT STAPLE
The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy	The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy
Rx #7 Tape computer receipt(s) - DO NOT STAPLE	Rx #8 Tape computer receipt(s) - DO NOT STAPLE
The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy	The receipt(s) must contain the following information: Prescription (Rx) Number Date prescription filled Name of drug NDC Number Quantity dispensed Day supply Amount paid Name and address of pharmacy

Claims returned for missing information:

Please provide highlighted information and resubmit.

- | | |
|---------------------|--|
| Claim form required | Amount Paid |
| Pharmacy receipt(s) | National Drug Code (NDC) |
| Patient ID number | Quantity |
| Date Dispensed | Days Supply |
| Prescription Number | Patient not in system, contact your health plan or employer. |

Other: _____

Explanation of Benefits

Your claims have been processed and no payment was made on the following claims for the reason(s) indicated:

	Rx Date	Rx Number	Rejection Code(s)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

1. The claims have been applied toward your deductible.
2. The claim reimbursement is less than your copayment.
3. The medication was refilled too soon, according to the plan design.
4. The claims submitted are for medications that are not covered under your plan.
5. The patient was not covered at the time the claims were incurred.
6. The claims have already been adjudicated by Script Care.
7. Claims older than ____ days/months are not eligible.
8. Your plan does not cover direct reimbursement claims.
9. Your plan allows only a ____ day supply through a retail pharmacy.
10. The claims submitted exceed maximum dispensing limits.
11. Other _____